MONTANA

State Department of Health and Environmental Sciences

MATERNAL AND CHILD HEALTH BUREAU

STATE PLAN

PREPARED BY MATERNAL AND CHILD HEALTH BUREAU
DECEMBER 1975

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SECTION I. CONDITIONS FOR STATE PARTICIPATION IN THE MATERNAL AND CHILD HEALTH -- CRIPPLED CHILDREN'S PROGRAM

A. Legal Basis

1. Laws

The 1967 Legislature passed Laws 69-4101 to 69-5912, which provides codification and general revision of the laws relating to the State Department of Health and Environmental Sciences, These revisions relating to Maternal and Child Health Administration are as follows:

69-4101. There is a State Department of Health within the Executive Branch of State Government.

69-4106. The state board may accept and expend federal funds available for public health services.

69-4110. Develop and administer a program to protect the health of mothers and children; (11) conduct health education programs; (12) supervise school and local public health nurses in the performance of their duties; (13) consult with the superintendent of public instruction on health measures for schools.

69-4115. (1) If information on infant morbidity and mortality will be used to reduce those problems, data relating to the condition and treatment of any person may be given to the department, Montana Medical Association, an allied society of the American Medical Association, a committee of a nationally organized medical society or research group, or to an in-hospital staff committee . . . . . (2) a person furnishing information under subsection (1) of this section is immune from suit for damages arising from the release of the data or publication of findings and conclusions based on the data (3) data supplied under subsection (1) of this section may be used or published only for advancing medical research or medical education in the interest of reducing infant morbidity or mortality. However, a summary of studies based on the data may be released for general publication (4) the identity of persons whose condition or treatment was studied is confidential and may not be revealed under any circumstances (5) any data supplied or studies based on these data are privileged communications and may not be used as evidence in any legal proceeding. Any attempt to use, or offer to supply the data or studies, without the consent of the person treated or his legal representative, is prejudicial error rsulting in a mistrial.

SECTION I. A. Legal Basis

1. Laws (cont'd)

69-4117. The State Board shall adopt rules for lighting, heating, ventilation, plumbing and sanitary arrangements for schoolhouses. Before any schoolhouse is constructed, plans must be submitted to the Department for approval. A schoolhouse must conform to the rules adopted by the State Board before being used.

69-4118. (1) The Department shall make sanitary inspections of schoolhouses, churches . . . or facilities where persons assemble. If the facility is found unsanitary, the Department demands the conditions be corrected within a reasonable time. If the unsanitary conditions are not corrected within the time specified, the building or facility is a public nuisance; (2) either the State Board or a Local Board of Health shall bring an action to correct the unsanitary conditions in the way provided by law for abating a public nuisance. (Amended 1971 to include jails)

69-4502. With approval of the State Board of Health, the State Department of Health has general supervision over local boards.

69-4503. With approval of the State Board, the director of the State Department of Health and Environmental Sciences may accept funds for public health from an agency or person, and allocate funds to local boards.

69-5302. Hospitals, Medical and Related Facility Survey and Construction

The State Department of Health and Environmental Sciences is the principal state agency for establishing and administering a statewide plan for construction, modernization, or operation of any hospital, medical or related facility for provision of care, treatment, diagnosis, rehabilitation, training, or related service.

69-5203. Hospitals, Hospital Related Facilities and Long-Term Care Facilities

(1) No person may operate a facility unless licensed by the State Department of Health and Environmental Sciences.

75-1904. Includes the provision for the cooperation of the public health nurse or school nurse or public health medical officers in taking a census of handicapped.

SECTION I. A. Legal Basis

10-901 Requires doctors, nurses, teachers, social workers to report cases of child neglect or abuse and provides immunity from liability where such report is made in good faith.

69-4110-1 Making the Department of Health and Environmental Sciences the Sole Agency for Comprehensive Health Planning. (This bill provides statutory recognition to the designation previously made by former Governor Tim Babcock. There will be no change in function.)

Title 19 Chapter 45 R.C.M. 1947 Increasing membership of local boards of health when appointed by county commissioners plus two appointees. (This bill also sets forth the terms of office of the members. All in all, it makes for more orderly arrangements of local boards of health.)

16-1904 Eliminating provisions that prohibit county budgets for exceeding more than 5% the amount appropriated in the budget approved for the preceding fiscal year. (The previous law when strictly interpreted, made it impossible for counties to add new public health and other services.)

Title 69 Chapter 61 R.C.M. 1947 Providing that minors may give legal consent to hospitals, public clinics or physicians for diagnosis and treatment for pregnancy or venereal disease. (This law will add one more way to insure adequate, early prenatal care for young unmarried mothers who might not otherwise see a physician because of fear or disclosure to their parents. Early adequate treatment is needed to prevent complications of venereal disease. Physicians, public health personnel and teachers are aware that this is postponed only because the minor did not want his or her parents told.

Title 69 Chapter 64 R.C.M. 1947 Creates a new State Board of Eugenics and established provisions for the voluntary sterilization of the mentally retarded.

Title 69 Chapter 62 R.C.M. 1947 Creating the Montana Commission on Alcohol and Drug Dependence. (The Commission is nominally under the supervision of the Board of Health, but could have its own policy making authority.)

Title 54 Chapter 1 R.C.M. 1947 Regulating the possession and sale of dangerous drugs by providing Montana with a Dangerous Drug Act.

SECTION I. A. Legal Basis

1. Laws (Cont'd)

11-4005. Authorizing cities and towns to require protective devices around open ditches.

Title 53 Chapter 10 R.C.M. 1947 — Providing for regulation, operation and registration of snowmobiles; allowing use of snowmobiles on highways and streets in certain conditions and by local permit.

31-130. Including motorcycle endorsements on driver licenses with those items which application must be made, making a new resident's out-of-state driving record a part of his record.

Title 82A Chapter 6 R.C.M. 1947 — The State Reorganization of executive Department Act enacted by the legislature in 1971 designated the Department of Health and Environmental Sciences as one of the twenty administrative agencies of the executive branch of the government. Created the department and all functions of the State Department of Health and Environmental Sciences. It transferred to the department the functions of the Montana Commission on Alcohol & Drug Dependence, and abolished advisory committees provided for in statutes as well as certain administratively created advisory committees including the venereal disease and immunization advisory committee, the laboratory advisory committee, the migrant health advisory committee, the hearing conservation advisory committee, the family planning advisory committee and the inter-departmental council on mental retardation. Advisory committees are now created by either a department head or the governor. The advisory bodies act only in an advisory capacity and have no other powers or duties.

Chapter 20 — Allows state medical assistant payments to persons whose income is below the federal requirements for assistance and to medically needy children under 21 years of age; sets priorities for the distribution of medical assistance fund.

Chapter 49 — Designates the Department of Administration to receive and coordinate the review of all school construction plans which require state agency approval.

Chapter 69 — Allows school district trustees to require all children, on enrollment, to be immunized against communicable diseases; types of immunizations and frequency of their administration to be recommended by the department of health; children may be exempted for medical or religious reasons.

1. Laws (Cont'd)

Chapter 74	Provides that no group disability policy or certificate of insurance, which, in addition to covering persons in the insured group, also covers members of such person's family, may be issued or amended in the state if it contains any limitation of coverage of newborn infants or persons in the insuredgroup from and after the moment of birth.
Chapter 94	Implements "adult rights" provision of the 1972 Constitution by granting certain rights to persons 18 years of age or older; includes right to: be licensed for certain occupations, marry without parental consent, lease or purchase state lands and serve as jurors.
Chapter 101	Authorizes the mental retardation center at Glendive to accept and admit mentally retarded persons not residing in Montana when the state has formally agreed to such admissions by agreement with another state.
Chapter 178	Provides the highway patrol board may issue a driver's license to persons having a history of epileptic seizures providing the person can show through written report from attending physician that his condition has stabilized.
Chapter 225	Abolishes the occupation health advisory committee.
Chapter 227	Repeals Section 69-4116, and provides for the screening of newborn infants to detect inborn metabolic errors; persons in charge of facilities wherein the child is born to administer tests under rules adopted by the Department of Health and Environmental Sciences, requires assistance on request from the Boulder River School and Hospital.
Chapter 228	Repeals Sections 69-4612, 4613, 4614, and 4615. Requires all women seeking prenatal care to submit to a standard Dold test; provides procedures and duties of physicians and forms for confidential report of test results, allows district court to waive test on religious grounds.
Chapter 248	Add test for rubella immunity to standard blood test given as prerequisite to the issuance of a marriage license.
Chapter 336	Defines "hospital facilities" in public hospital district as a hospital or a hospital related facility, including out-patient facility, public health centers, rehabilitation facilities, long-term care facilities and infirmaries.

SECTION I. A. Legal Basis

1. Laws (Cont'd)

Chapter 383	Authorizes the Department of Health to adopt rules for construction and operation of trailer courts to insure sanitation and protect public health.
Chapter 392	Provides that cities and towns may establish and maintain licensed day care centers; authorizes mil levy up to one mil for such purposes.
Chapter 412	Amends the dangerous drug act by adopting definitions, procedures, standards and schedules which are substantially the same as the uniform controlled substances act.
Chapter 448	Broadens and redefines terms used to define hospitals, hospital-related facilities, long-term care facilities and related health care facilities.
Chapter 485	Includes retirement homes and rooming houses as transient lodging establishments subject to the control by the Department of Health and Environmental Sciences.

SECTION I. A. Legal Basis

2. Regulations

16-2.6 (1) - S610 On September 15, 1950, the Montana State Department of Health and Environmental Sciences adopted the following regulation which is still in effect:

"It shall be the policy of the Montana State Board of Health that all records and information concerning individuals, received in the office of the Department of Health be considered confidential and shall not be divulged by its employees to anyone without the consent of the individual concerned except as may be necessary to provide necessary care for the individual or in the protection of the community, and then only shall be divulged to professional persons or public officials who are specifically concerned with the situation. Otherwise, information available to the State Department of Health shall be released only in reports of a statistical or tabulary nature.

16-2.18 (6) - S1830 Operation of Day Care Centers

1. Definition

"A Day Care Center shall mean any day care facility that receives seven or more children for care for five or more hours of the day for five or more consecutive weeks. It may include facilities known as child care centers, nursery schools, day nurseries, and centers for the mentally retarded." (Chapter 247, M.S.L., 1965)

2. Regulations (Con't)

Operation of Day Care Centers (Con't)

2. Physical Facilities

The building shall meet the legal requirements of the community as to zoning, sanitation, fire protection, water supply and sewage disposal. Where local regulations do not exist, laws and regulations of the Montana State Board of Health and State Fire Marshall shall prevail.

Water shall be from a source approved by the Montana State Board of Health. Any wells, springs, or cisterns in use shall be located, constructed and maintained in an approved manner, approved by the Montana State Board of Health. The Board of Health may require, when the day care center water supply is not from an approved public water supply, periodic inspections and examinations of the water to determine its quality in the same manner as the Board does for public water supplies.

All plumbing shall be designed to meet the minimum requirements of the Montana State Plumbing Code. Where a public sewer system is available all plumbing fixtures shall be connected to that sewer. Private Sewer disposal systems shall be approved by the Montana State Board of Health.

Provision for Health Care

1. Every person coming in contact with children in the day care center shall have an examination by a physician. The examination shall be for the purpose of determining that the person is free from any physical or mental illness which might conflict with the children's interest. It will include a test or tests, to determine the presence, or absence of active pulmonary tuberculosis. This requirement would pertain to all employees and to all family members and others residing in the facility. All family members and other children residing in the facility, under 12 years of age, shall be immunized against diptheria, smallpox, polio, and measles. In addition, children under 5 years of age shall be immunized against whooping cough. Any child with a history of measles would be considered immunized. Such examinations and immunization history will be recorded on forms provided by the Montana State Board of Health. The licensee shall keep such medical certificates on file.

2. Regulations (Cont'd)

Provision for Health Care

2. No child shall be admitted to a day care center, except in an emergency, before obtaining from his physician the "Medical Record for Children Receiving Day Care," prescribed by the Montana State Board of Health, stating that he is free from communicable disease and that he has been immunized, or is in the process of being immunized, against smallpox, diphtheria, tetanus, polio and measles.

In addition, children under five years of age shall be immunized against whooping cough. Any child with a history of measles would be considered immunized. These requirements would be waived only in the case of a signed statement by a physician indicating that immunizations would be contraindicated for health reasons.

Such medical records shall be on file at the center for each child enrolled. Parents should obtain for all children an Immunization Record Card showing the dates of immunization.

Serological tests for Prenatal Care

16-2.18 (6) - S1850

1. Approved Blood Tests: The approved tests shall include a standard serological test for syphilis, rubella immunity, and blood group including O,A,B, AB, and Rho (D).

2. Approved Laboratory: The required prenatal tests shall be done in a laboratory approved by the Department of Health and Environmental Sciences.

16-2.18 (6) - S1850

ABORTION CONTROL ACT, DOCUMENTS AND STUDIES REQUIRED TO COMPLY WITH ACT

1. Definitions
   a. Abortion means the performance of, or assistance or participation in the performance of, or submission to, an act or operation intended to terminate a pregnancy without live birth.

   b. Viability means the ability of a fetus to live outside the mother's womb, albeit with artificial aid.

   c. Facility means a hospital, health care facility, physician's office or other place in which an abortion is performed.

16-2.18 (6) - S1850 (Continued)

d. Department means the Department of Health and Environmental Sciences.

2. Certificate of informed consent for abortion.
The written statement of informed consent required by Section 94-5-615 (3), R.C.M. 1947, is to be made on a form prescribed by the department. The attached form entitled "Certificate of Informed Consent for Abortion" is adopted as the form for informed consent. By this reference hereto the form is incorporated herein and is made a part of this rule.

3. Facility report.
Every facility, as defined herein, shall keep on file a statement dated and certified by the physician who performed the abortion setting forth the hereinafter described information with respect to such abortion. The attached form entitled "Facility Report" is adopted as the prescribed form of the department. By this reference hereto the form is incorporated herein and is made a part of this rule. The following information is required:

a. Name, address, date of birth, marital status, race and patient identification number of the woman upon whom the abortion was performed.

b. If married, the name and address of her husband, unless voluntarily separated from her.

c. If a minor and unmarried, name and address of her living parents, or her custodian or legal guardian.

d. Statement whether or not husband, parent or legal guardian has been notified of the abortion.

e. The information as to the first day of the last normal menses as provided by the woman and the number of her prior pregnancies, live births, miscarriages, induced abortions and living children.

f. Name and address of the public or private agency, other than a medical facility, if any, referring the woman to the physician in connection with the abortion; but the name of the individual so referring shall not be stated.

g. Name and address of the public or private counselling agency, if any, to whom the physician has referred the woman for counselling; but the name of any individual connected with such agency shall not be stated.

h. The date, and the name and address of the facility in which the abortion was performed, and the name and address of the physician performing the abortion.

16-2.18 (6) - S1850 (Continued)

i. Information upon which the physician concluded the patient was pregnant.

j. The reason for the abortion, if given.

k. The medical procedure employed to administer the abortion.

l. The approximate gestational age, length and weight of the fetus.

m. The vital signs of the fetus, after abortion, if any.

n. If viable, the medical procedures employed to preserve the life and health of the fetus.

o. If a premature infant was born alive and viable and the infant did not survive, the apparent cause of death.

p. If the fetus was viable, but was endangered or destroyed during the abortion procedure prior to birth, the reason therefor.

q. Complications in the woman resulting directly or indirectly from the abortion.

4. Pathology studies.
The products of conception and any other tissue removed as a consequence of the abortion shall be examined by the physician performing the abortion or by a pathologist. The pathology examination shall include, but not be limited to, a gross examination, and may include other studies at the discretion of the attending physician or the pathologist, including studies for the presence of micro-organism or genetic defects. If the products of conception are referred to a pathologist, or if the abortion is performed within a hospital, the physician performing the abortion shall insure that all of the products of conception and any other tissue be delivered to the pathologist. If the gross examination fails to provide evidence of pregnancy, a microscopic examination shall be performed to obtain such evidence. The physician performing the abortion or the pathologist, whichever conducts the definitive examination, shall file with the facility, and the facility shall keep on file a report containing such information as would be customarily included in such a report, and including but not limited to the following:

SECTION I. A. Legal Basis

16-2.18 (6) - S1850 (Continued)

a. Evidence as to whether the woman was in fact pregnant,

b. The medical procedure employed to administer the abortion.

c. The approximate gestational age, length and weight of the fetus, if possible to determine.

d. Any apprent abnormalities observed in the products of conception.

If, as a result of the abortion, a premature infant was born alive and viable, but subsequently died, the dead infant shall be delivered to a pathologist for post-mortem examination, and the report thereof shall indicate the above information and also the apparent cause of death. This requirement is subject to the provisions of Section 69-5103 (4), R.C.M. 1947, if applicable.

5. Reports and documents --confidentiality.

a. In connection with an abortion, the facility shall keep on file the original of each of the documents required by the Montana Abortion Control Act relating to informed consent, notice of abortion, certification of necessity of abortion to preserve the life or health of the mother, and certification of necessity of abortion to preserve the life of the mother.

b. All reports and documents required by this act shall be treated with the confidentiality afforded to medical records, subject to such disclosure as is permitted by law.

6. Disposition of fetus or dead infant.

a. The products of conception and any other tissue removed as a consequence of the abortion, except such tissue as necessary for examination, shall be disposed of in a manner similar to that for other surgically removed tissue at that facility, and in a way that does not endanger public health nor create a public nuisance.

b. However, any dead fetus or infant having been removed after twenty weeks gestation may be disposed of by the facility only if the surviving parent or parents so authorize the facility. If the surviving parent or parents do not wish the fetus or infant to be disposed of by the facility, they then will be responsible for the disposition of the remains in a humane manner of their choosing.

16-2.18 (6) - S1850 (Continued)

c. In the event that the facility is unable to secure an authorization, the facility may dispose of the dead fetus or infant in the manner indicated in subsection (a) above.

(History: Sec. 94-5-615, 94-5-617 and 94-5-619, R.C.M. 1947; NEW: EMERG: Order MAC No. 16-2-10; Adp. 6/28/74; Eff. 7/1/74; NEW: MAC Not. No. 16-2-33; Order MAC No. 16-2-12; Adp. 8/15/74; Eff. 10/5/74.)

SECTION I. B. EMPLOYMENT

1. Merit System Employment

Employees of the State Department of Health and Environmental Sciences are covered by a merit system of personnel administration established in compliance with the Federal Social Security Act and state law to assure fair treatment of all employees in all personnel actions. This same coverage is extended to employees of full-time local health departments and to employees of those part-time local health departments which are assisted financially with state or federal funds.

2. Sub-Professional

Sub-professional workers have not been employed extensively in Montana; and so far, none have been employed specifically for MCH or CC Programs except for clerks, attendants, and aids.

Non-paid voluntary staff are utilized extensively in programs, particularly in programs aimed to reach the "mass." Among these are preschool vision screening programs, hearing screening programs, diabetes detection, mental retardation, EPSDT, and immunization programs. The most usual method is through their participation in community organization. The health education staff of the department does the organization. These non-paid volunteers participate in planning the activity, in carrying out some of the screening techniques.

In programs requiring professionally trained persons such as the drawing of blood in the diabetes detection program, volunteer nurses are utilized and the non-professional volunteers keep the records, register the individuals and carry out similar duties.

Non-professional volunteers assist at well child conferences, health appraisal screening programs, etc.

In programs such as preschool vision screening and in hearing screening programs, the non-professional workers are trained to conduct the screening tests as well as to carry out registration, guding record keeping, etc.

3. Supervision of State Plan at the Local Level

The areas where there are local full-time health departments are shown on Fig. 1 and Nursing Services are shown on Fig. 2, Appendix.

The services described in the State Plan are carried out in communities.

For the most part, personnel responsible for activities and programs are employees of the Montana State Department of Health and Environmental Sciences. Such personnel are responsible to the Chief of the Maternal and Child Health Bureau. The Chief of the Bureau of Nursing and Public Health Education provide supervision within their professional competencies.

Some segments of the State Plan are carried out by personnel of other agencies. The other agencies are local health departments, school nurses and other school personnel, and county departments of Welfare. The activities of local health departments are supervised by the State Department of Health and Environmental Sciences. This is a statutory requirement under Section 69-4502, RMC 1947, See "A - Legal Basis" in this section.

Local health departments are encouraged to undertake maternal and child health programs.

Policies, guides, and criteria are given to local health departments to assist them in carrying out the provisions of the State Plan. Personnel of local departments are given professional consultation by their counterparts from the State Department.

No local health departments, or any other agency, for that matter, operate a Crippled Children's Program separate from the State Program. Local public health nurses refer cases to the State Program and do family social studies which are used by the State Department to determine eligibility. Nurses employed by local school board's work in school health programs, as do most of the local public health nurses. All school nurses are supervised by the Montana State Department of Health and Environmental Sciences.

County Departments of Welfare, particularly in counties which do not have public health nurses, act as agents for the State Crippled Children's Program. The local caseworkers do family social studies which are utilized by the State Department of Health and Environmental Sciences in determining eligibility.

SECTION I. C. SUPERVISION OF ADMINISTRATION (Continued)

1. The Maternal and Child Health Bureau is responsible for the planning, promoting, and coordinating of all MCH and Crippled Children's Programs conducted by the Department. The Chief of this Bureau is Director of both MCH and CC Programs.

2. All MCH and CC Programs provided on the local level are supervised by the MCH Bureau. The personnell of the Bureau through the Bureau Chief consults with local programs which have an MCH or Crippled Children component. Since these local programs are used in part as basis for MCH and CC matching funds, records are kept which show that the services are accounted for in the appropriate MCH categories. The relationship to local health departments is described in Section II, Subsection A.

SECTION I. D. FINANCIAL ASSISTANCE

1. Aid to Counties

Primarily through the use of PHS Health Grant Funds, aid to local health departments has continued to increase. Assistance is given for the initiation of new services or for the expansion of existing local health services to include new areas not previously providing public health services.

2. Methods which will be used to validate the distribution of costs attributable to categorical grant-aided public health programs.

General rule governing charging expenditures to projects:

The expenditure or activity base against which validation procedures are applied will not include any expenditures or activities which are paid or reimbursed from other Federal fund sources, which are being used to match other Federal grant funds, or for which fees are received from patients or from public or private agencies.

Salaries and travel expenses of staff members will be charged to the project budget for the organizational unit or activity to which they are administratively assigned. Other expenses will be charged to the project budget for the organizational unit or activity for which such expenses are incurred, with the following exceptions:

The salary of the Chief of Maternal and Child Health Bureau will be charged one-half to Project 0401, Maternal and Child Health (MCH), and one-half to Project 0402, Crippled Children Services (CCS).

Any supplies, services, equipment, etc., which cannot be identified as being exclusively for the use of a single project unit or activity will be charged to Project 0201, General Administration. Supplies issued from general stores on requisition for project units will be charged to the projects at cost, with an offsetting credit to General Administration.

In any instance where staff members are charged to budget projects for the organizational unit or activity to which they are not attached administratively, salary and travel of such staff members will be deducted from other costs charged to the project and validated separately on the basis of the certification of the Chief or Administrator of the organizational unit or activity to which such staff member is administratively responsible, based on time studies or other available objective data.

SECTION I. E. PUBLIC INFORMATION

The Department's efforts to acquaint interested persons, organizations and the general public with MCH and CC programs are as follows:

1. Continuing Committees

   a. The cooperative efforts between the Maternal and Child Welfare Committee of the Montana Medical Association have done much over the years and will continue to contribute to physician understanding of the programs. Program information is given to the MMA Orthopedic and Fracture Committees and the Academy of Otolaryngology.

   b. The Montana Medical Association's Public Health Committee meets regularly to correlate the activities of the various advisory committees such as the Family Planning and Hearing Conservation Programs. Both consumers and providers are included in these advisory committees.

2. Talks at PTA and civic groups are given to bring attention to the MCH and CC Programs.

3. News Media

   Periodically news releases are prepared and distributed Statewide to the news media: The Associated Press, the United Press International, radio and TV stations.

   Frequently feature articles are prepared for specific papers when the activity involves the part of the State the paper, TV or radio station serves. This is particularly true of the local programs the SDH staff is working in, such as Hearing Conservation or Amblyopia Screening, and Early and Periodic Screening, Diagnosis and Treatment. Most of these are prepared by the State staff, the remainder by local people with State staff assistance.

   The State Personnel are often asked to make talks or serve on panels for TV programs.

   The Department's official bulletin, Treasure State Health, published monthly, carries information about programs or parts of programs, information on handicapping conditions or disease. This publication has a distribution of approximately 3,000 for each issue. Often these articles are picked up by the media and reprinted.

SECTION I. E. PUBLIC INFORMATION (Continued)

4. MCH and CC programs are included in the annual report to the Governor, It is specifically prepared by legislative direction, and in addition, copies are distributed to cooperating and interested agencies, interested citizens as well as professional persons working in health and related fields.

5. Information on the programs of MCH and CC is included in the Guide for the Montana School Health Program for teachers.

6. Brochures are provided on: The Cleft Lip-Palate Program, Pre-School Vision Screening Program, Hearing Conservation Program, Child Health Services, Nutrition, and others.

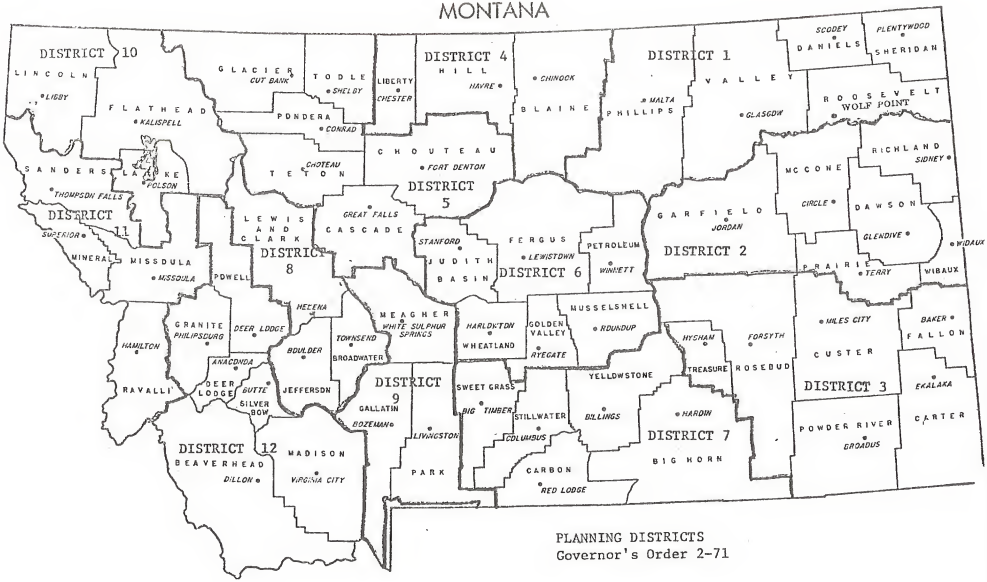
SECTION I. F. STATE REPORTS AND RECORDS.

All reports and records required by the Federal Government will be furnished. These will include but not limited to the disposition of all funds expended and other necessary annual reports.

SECTION I. I. ORGANIZATION CHARTS

The following charts show the organization of the State Department of Health and Environmental Sciences, Maternal and Child Health Bureau, Crippled Children's Services Programs, and Centralized Services Division which includes the fiscal and personnel offices. Also are charts showing the Governor's Planning District and comprehensive health plan regions that are used for planning of services for the Maternal and Child Health Bureau.

The Maternal and Child Health Bureau is under the direction of the Health Services Division Administrator who is a physician, employed by the State Department of Health, and is a full-time director to the agency.



PLANNING DISTRICTS
Governor's Order 2-71

No. 1052 — County Outline Map
STATE PUBLISHING COMPANY
Helena
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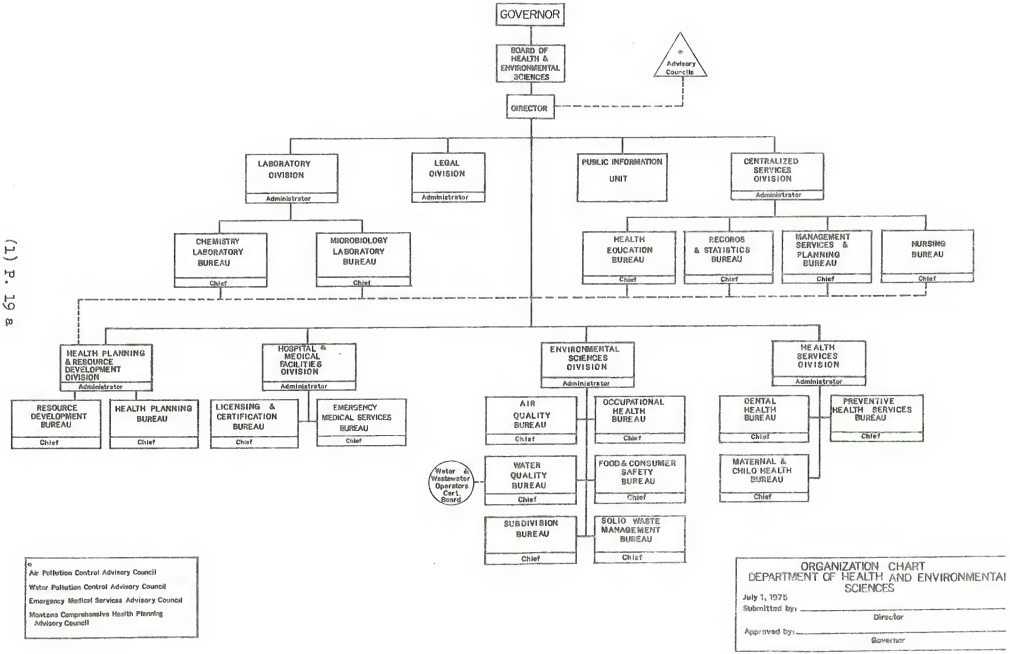
GOVERNOR
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Administrator
ENVIRONMENTAL SCIENCES DIVISION
Administrator
HEALTH SERVICES DIVISION
Administrator
RESOURCE DEVELOPMENT BUREAU
Chief
HEALTH PLANNING BUREAU
Chief
LICENSING & CERTIFICATION BUREAU
Chief
EMERGENCY MEDICAL SERVICES BUREAU
Chief
AIR QUALITY BUREAU
Chief
OCCUPATIONAL HEALTH BUREAU
Chief
WATER QUALITY BUREAU
Chief
FOOD & CONSUMER SAFETY BUREAU
Chief
SUBDIVISION BUREAU
Chief
SOLID WASTE MANAGEMENT BUREAU
Chief
Water & Wastewater Operators Cert. Board
DENTAL HEALTH BUREAU
Chief
PREVENTIVE HEALTH SERVICES BUREAU
Chief
MATERNAL & CHILD HEALTH BUREAU
Chief
a
Air Pollution Control Advisory Council
Water Pollution Control Advisory Council
Emergency Medical Services Advisory Council
Montana Comprehensive Health Planning Advisory Council
ORGANIZATION CHART
DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES
July 1, 1975
Submitted by: Director
Approved by: Governor

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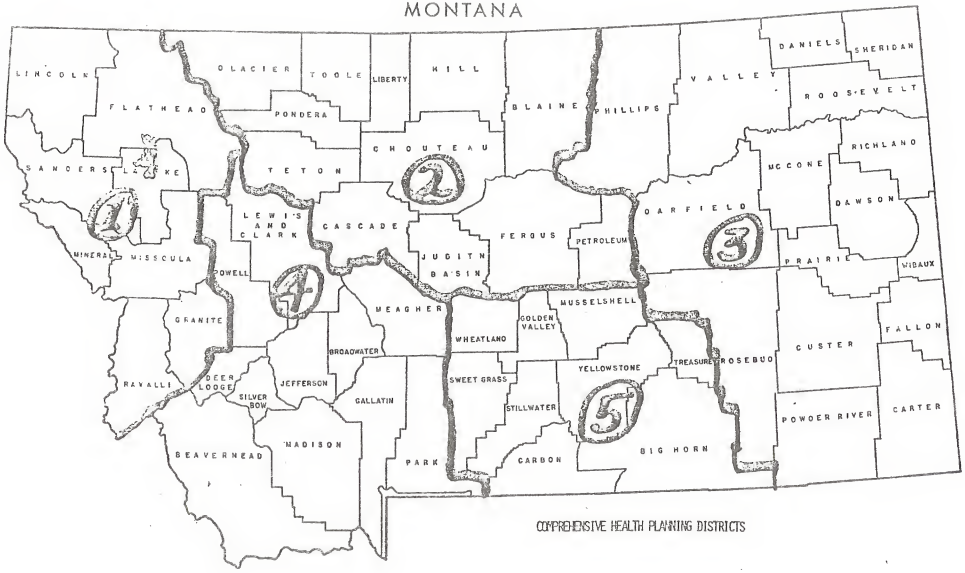
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HILL
BLAINE
PHILLIPS
VALLEY
DANIELS
SHERIDAN
ROOSEVELT
PONDERA
CHOUTEAU
SANDERS
LAKE
TETON
RICHLAND
MCCONE
DAWSON
LEWIS AND CLARK
CASCADE
FERGUS
PETROLEUM
GARFIELD
MINERAL
MISSOULA
POWELL
JUDITH BASIN
PRAIRIE
WIBAUX
GRANITE
MEAGHER
MUSSELSHELL
GOLDEN VALLEY
FALLON
WHEATLAND
BROADWATER
CUSTER
RAVALLI
DEER LODGE
JEFFERSON
SILVER BOW
GALLATIN
SWEET GRASS
YELLOWSTONE
TREASURE
ROSEBUD
STILLWATER
POWDER RIVER
CARTER
BEAVERHEAD
MADISON
PARK
CARBON
BIG HORN
1
2
3
4
5
COMPREHENSIVE HEALTH PLANNING DISTRICTS

SECTION II. COORDINATION AND COOPERATION

SECTION II. COORDINATION AND COOPERATION

A. Arrangements with Other State and Local Health, Welfare, Rehabilitation, and Education Units for Providing MCH and CC Services.

1. Local Health Units
2. Welfare
3. Early and Periodic Screening, Diagnosis and Treatment.

B. Cooperation between the State MCH and CC Program with Tital XIX.

C. Relationship of the MCH and CC Programs to State Comprehensive Planning.

C. Direct Services to MCH and CC Programs by Other Units of the State Department of Health and Environmental Sciences.

1. Administration
2. Disease Control

SECTION II. COORDINATION AND COOPERATION

A. Arrangements with other State and local health, welfare, rehabilitation and education units for providing MCH and CC services.

1. Local Health Units

The areas of the State where there are full-time and part-time health departments are shown in this Plan. Local Public Health Nursing Services are shown also.

a. CC Services

As was mentioned under Section I, Subsection C, administration, local health departments do not operate crippled children services directly and independently from the State program. All decisions concerning eligibility and arrangements for services are made at the State level.

Local health departments serve in many ways to make the Crippled Children's program effective. Local health departments serve as information and referral sources.

Local health officers and public health nurses are familiar with Crippled Children's policies and procedures. They interpret the program to referring sources and families.

Local public health nurses assist in making appointments to, and arrangements for, crippled children evaluation clinics.

Public Health Nurses provide follow-up and assist the State program in obtaining needed information.

Public Health Nurses assist families in making application to Crippled Children's Services.

b. MCH

All local health departments have Maternal and Child Health programs. These vary in extent from county to to county. All have family health nursing services. Others include school health, well-child conferences, immunizations, vision and hearing screening, and education for parenthood classes.

In addition the local health department personnel assist the State on state programs performed in their jurisdiction.

SECTION II. COORDINATION AND COOPERATION

A. Arrangements with other State and local health, welfare, rehabilitation and education units for providing MCH and CC services (Cont'd)

2. Welfare

Crippled Children's Program arranges special medical evaluations of handicapped children for use in social planning at the request of any of the state child placing agencies. We believe this has been an important factor in the outstanding success of these agencies in finding adoptive homes for handicapped children.

3. Early and Periodic Screening Diagnosis and Treatment

In August of 1972 a contract was signed between the Montana State Department of Health and Environmental Sciences and the Montana State Department of Social and Rehabilitation Services, a medical assistance program that provides the required early and periodic screening diagnosis and treatment to all children receiving medical assistance who are under 21 years of age.

4. TITLE XX - See Under Family Planning

5. Rehabilitation

The Division of Rehabilitative Services and Child Health Services have worked closely together for many years. We do not have a "formalized" contract but we share cases and cooperate in planning for care. The age group from 16 to 21 is the shared group. When a child is over age for CHS, the individual is referred for continued care to Rehabilitative Services. This same relationship is maintained with the Prevention of Blindness Program which is administered by the Department of Social and Rehabilitative Services. There is a formalized contract between SRS and the Hearing Conservation Program. (See Appendix)

6. Education Units

a. Joint Staff Committee - State Department of Health and State Department of Public Instruction.

b. Teacher training units of the Universities and Colleges in Montana.

The Department's relationship with these units has been described in the School Health Program Section of this Plan.

c. Workshops sponsored jointly by the University of Montana and the State Department of Health in Education for Parenthood are described in this Section.

SECTION II. COORDINATION AND COOPERATION

A. Arrangements with other state and local health, welfare, rehabilitation and education units for providing MCH and CC services. (continued)

6. d. Education Units

Cooperative relationship with the Montana Education Association have also been described in Section III.

Coordination with Mountain States Regional Medical Program and Montana State University to develop and implement workshops on the expanded role of the nurse.

e. Coordination with Division of Indian Health to develop and implement workshops on the expanded role of the nurse working with the native Americans.

State Health Department staff, other than nursing, are asked to serve as guest lecturers from time to time and to assist in preparing television lecture series, etc. Demonstration and instruction are provided in all schools of nursing on request when possible.

SECTION II. COORDINATION AND COOPERATION

B. Cooperation Between the State MCH and CC Program with TITLE XIX

The Agreement between the Montana State Department of Health and and Environmental Sciences, and the Montana Social and Rehabilitation Services states:

a. Purpose:

The purpose of this agreement is to formalize and extend basic working relationships between the Department of Health and Environmental Sciences and the Department of Social and Rehabilitation Services. Such agreement will assure a high standard of medical care and services; eliminate duplication, provide consultation on program expansion, and evaluation of medical care.

b. The Department of SRS agrees to the following:

1. Designate members of its staff to meet on a quarterly basis (each 3 months) with the Department of Health and Environmental Sciences.

2. To act as a referral source in areas other than crippled children's services and provide limited social information when such services are required by the State Department of Health and Environmental Sciences.

3. Exchange medical and social information on individual cases.

4. The Department of Social and Rehabilitation Services will provide funds to the Department of Health within limitations to be hereafter agreed to from time to time by the parties, giving consideration to existing budgetary conditions for all actual necessary expenses which the Department of Public Health incurs in carrying out the duties and responsibilities outlined herein.

5. Accept all standards for medical care and services as set forth in regulations for nursing homes, hospitals, home health agencies, and crippled children's services as developed by the State Department of Health and Environmental Sciences.

6. The department will refer all children who are medically eligible for crippled children's services and when it has been determined by the Health Department and the Department of Social and Rehabilitation Services that additional funds are needed, the Crippled Children's Program will bill the Department of Social and Rehabilitation Services direct for services provided on behalf of an eligible child.

B. Cooperation Between the State MCH and CC Program with TITLE XIX (Cont'd)

7. To inform the field staff, county directors and case-workers of all health services available through the state and local health departments.

c. The State Department of Health and Environmental Sciences agrees to the following:

1. Designate members of its staff to meet on a quarterly basis (each 3 months) with the Department of Social and Rehabilitation Services.

2. Exchange medical records in individual cases.

3. To provide appropriate health department staff as consultants for program expansion and evaluation and staff development.

4. To provide that individuals eligible for medical assistance may use free the services obtained from special projects sponsored by the State Department of Health and Environmental Sciences, such as lazy eye clinics and dental screening programs, except where there is an established fee for all individuals.

5. Will provide crippled children's services for the following conditions: congenital anomalies, neoplasms, conditions which impair hearing, orthopedic and neurologic handicaps amenable to surgical treatment, rheumatic fever and cystic fibrosis, as the Department of Health and Environmental Sciences may designate.

6. Provide for diagnostic and consultation for children on medical assistance who are eligible for crippled children's services.

7. Provide on-site inspections during the licensing process for all nursing homes and hospitals. A copy of the Observation Report Questionnaire will be sent to the Department of Social and Rehabilitation Services when it is completed. An on-site inspection will be completed on a yearly basis.

d. Both Agencies Agree:

To promote educational and other information programs designed to make medical assistance and health services known to all persons in the state and create better public understanding of the benefits of these services.

SECTION II. COORDINATION AND COOPERATION
(Cont'd)

C. Relationship of the MCH and CC Programs to State Comprehensive Planning

The State Department of Health and Environmental Sciences was designated by Governor Tim Babcock as the State Comprehensive Health Planning Agency. This agency became operational in March 1968 with the selection of a Director and the appointment of an Advisory Council. The Advisory Council had two meetings during fiscal year 1968. In 1969 a bill was passed making the State Department of Health and Environmental Sciences the sole Comprehensive Health Planning Agency, giving this legislative status.

Until the State Comprehensive Health Planning program has developed a work program, it is not possible to describe how the staff of the MCH and CC program will relate to it.

It is anticipated that the State Health Planning Agency will provide consultation to the MCH and CC programs in the area of improving the planning process. The MCH and CC programs will be able to furnish statistical and other information that will be useful for state health planning purposes.

D. Direct Services to MCH and CC Programs by Other Units of the State Department of Health and Environmental Sciences

1. Administration

The Maternal and Child Health Bureau is responsible for the Maternal and Child Health and Crippled Children's Programs.

All fiscal operations are supervised by the Centralized Services Division Administrator.

The primary duties of his office are personnel and business management for the agency. The office is responsible for the management of resources necessary in conducting public health programs, for giving assistance to program enterprises in the management of money, personnel, materials, equipment, and miscellaneous services.

The Administrator oversees the preparation and justification of financial budgets, maintenance of accounting records of business transactions and the preparation of accounting reports on all agency operations. He confers and negotiates with State and Federal agencies regarding financial grants and reports. Consultation is furnished to program personnel regarding project financing.

The office management functions of the division consist of budgeting and accounting for department business. The accounting responsibility requires the payment of claims for medical services, hospitalization and other services, the processing of agency payrolls, the proper recording of activities and the preparation of reports for state and federal agencies. The division carries out the purchasing activities for the department and maintains proper y control records.

The administrator has the principal responsibility for recruitment of personnel. This is done through advertising, personal contact and the screening of personnel registered with the State Merit System. He interviews, screens and investigates job candidates and assists in placing them in positions for which they are qualified. He is a resource to staff personnel in cases of grievances or other problems and serves as a consultant to the Executive Officer and other division directors on personnel matters.

D. Direct Services to MCH and CC Programs by Other Units of the State Department of Health and Environmental Sciences

1. Administration (Cont'd)

Specifications are prepared for new personnel classifications and old classifications are kept up-to-date. Surveys are made to ascertain current general personnel policies, status of salaries and typical job duties. Assistance is provided in the implementation of training programs, payment for formal training, and maintenance of records of employee training accomplishments.

The administrator furnishes miscellaneous services for the support of program activities. Mail and courier service among the divisions is provided, a printing shop is operated for the production of agency forms and educational materials and many miscellaneous services of benefit to employees and the agency are provided.

2. Disease Control

There is a close relationship between the MCHB and the Preventive Health Services Bureau. Many of the programs in the Preventive Health Services Bureau directly affect the health of mothers and children. Other than the ones mentioned in this Plan such as: immunization, communicable disease control, safety, heart diagnostic center services, any unusual occurrence of cancer in children is studied. The Chief of the Preventive Health Services works with the cancer committee of the Montana Medical Association which advises on problems relating to cancer control not only in adults but among children as well.

Diabetes screening has been offered, particularly in high risk groups which included mothers of large babies and their teen-age families. Counseling of these people was done and referral for any definitive diagnosis necessary was made to their own physicians.

A child-centered program is being carried out and will be continued in TB control as a part of the program for its eradication.

Complete epidemiological study of venereal disease is done, which very often extends into not only the teen-age group but even among children. They are referred to their own physicians for care.

SECTION III. MATERNAL AND CHILD HEALTH AND CHILD HEALTH SERVICES (CCS) PROGRAM SCOPE AND CONTENT

SECTION III. MATERNAL AND CHILD HEALTH AND CHILD HEALTH SERVICES (CCS) PROGRAM SCOPE AND CONTENT

A. MCH - Scope and Content

1. Infant and Maternal Death Studies and Nursing Programs, High Risk Mothers and I fants
2. Perinatal Education
3. School Health Program including Education for Parenthood, Sex and Secuality Education
4. Nutrition
5. Preschool Vision Screening
6. Hearing Conservation
7. Social Services
8. Screening of Newborns
9. Dental Health
10. Communicable Disease Field Services
11. Nursing
12. Family Health Nursing Services
13. Family Planning

B. CC - Scope and Content

1. General

SECTION III. MATERNAL AND CHILD HEALTH AND CHILD HEALTH SERVICES (CCS) PROGRAM SCOPE AND CONTENT

A. The MCH Program - Scope and Content

1. Infant and Maternal Death Studies and Nursing Programs High Risk Mothers and Infants

Maternal and Infant Death Studies

a. Goal

To assist in reducing the unnecessary maternal and infant deaths in Montana.

b. Needs and Problems

There are still too many unnecessary infant deaths in Montana, some caused by the lack of prenatal care -- the mother's not seeking it, some due to poor nutrition and some due to medical practice that could be improved.

c. Method

The State Department of Health maintains a close relationship with the Montana Medical Association through its part-time pediatric consultant. The Maternal and Child Welfare Committee of the Montana Medical Association conducts studies of maternal deaths and perinatal deaths.

Maternal deaths are reported from the Division of Records and Statistics and questionnaires are sent to the attending physician. The returned information is reviewed and in special instances consultation is provided. A report entitled "Perinatal Death Study" is published. From information furnished by the Division of Records and Statistics, a report on infant, neonatal and stillbirths by Montana hospitals is published yearly.

d. Measures of Progress, Evaluation and Plans for Extension

The work of this Committee ever since its inception in the early 1930's has made a tremendous contribution to the reduction of Maternal and Infant Deaths. The continuation of this Committee over this long period of years is an attest to the enthusiasm and devotion to the problems of mothers and infants.

SECTION III. MATERNAL AND CHILD HEALTH AND CHILD HEALTH SERVICES (CCS)
PROGRAM SCOPE AND CONTENT

A. The MCH Program - Scope and Content (Continued)

2. Perinatal Education

a. Goals

To improve and extend the Perinatal Education Program through inservice training of leaders in discussion methods and working with groups.

b. Needs and Problems

This program is not reaching as many people as it might although it has been an ongoing program since 1954. Upon request individual instruction is given by the MCH Nursing Consultant to nurses preparing them to teach classes. Turnover in staff makes an ongoing educational program essential for success.

c. Methods

A new Perinatal Education Manual has been developed and is available to those teaching Perinatal classes. Other interested professionals may purchase the manual at cost. Workshops in Perinatal Education have been offered at several locations in the state. Those in attendance were public health nurses, hospital nurses, volunteer registered nurses; all teaching perinatal classes. Several nutritionists also attended.

Many areas are offering Lamaze classes.

The MCH Nursing Consultant will give guidance to program planning and to the development of nurse leaders on request.

d. Measures of Progress, Evaluation and Plans for Extension

It is gratifying to find a substantial increase in the number of expectant parents enrolled in this program - especially father participation. Since films and other educational materials are provided by the State Department of Health and Environmental Sciences for each series, it is possible to control the quality of the presentations to a degree.

The materials are made available only to those nurses in local areas who have been prepared either by attending a workshop or through individual instruction.

SECTION III. MATERNAL AND CHILD HEALTH AND CHILD HEALTH SERVICES (CCS)
PROGRAM SCOPE AND CONTENT

A. The MCH Program - Scope and Content (Continued)

3. School Health Program

General

a. Goal

The goal of the School Health Program is to assist in improving the health of school-aged children and school personnel through the critical areas of health education, a healthful school environment and adequate health services.

b. Needs and Problems

An increase in interest in the area of school health education has prompted us to provide major emphasis in the schools regarding health consultation, health education, services, and environment. Nurses working in the school health programs, as well as teachers need to be upgraded through short-term educational offerings. Dental health is another area of need and is included in another section of this Plan.

Non-hazardous environmental surroundings are needed inside and outside of all school buildings. It is important that existing buildings be maintained and replaced as required. The impact of more densely populated trailer courts around some schools is being monitored for problems of over-crowding including adequate sanitary facilities.

c. Methods

The Health Education Consultant of MCH is becoming increasingly involved in school health. We have selected six districts in Montana which will receive unlimited assistance toward upgrading of school health programs.

The Joint Staff Committee between the State Department of Health and Environmental Sciences and the State Department of Public Instruction continues actively. It has four representatives from each agency. Started in 1951 it meets regularly at least quarterly or bimonthly. Its purpose is to bring to discussion health problems of school-aged children and it serves as a coordinating body between the two departments. The Joint Staff Committee of the Advisory Council is composed of state education and health associations, and meets annually.

SECTION III. MATERNAL AND CHILD HEALTH AND CHILD HEALTH SERVICES (CCS)
PROGRAM SCOPE AND CONTENT

A. The MCH Program - Scope and Content (Continued)

3. School Health Program

c. Methods (Continued)

The Council was formed soon after the Joint Staff Committee was organized and continues to provide a great deal of assistance in the development of various aspects of school health. It promotes closer coordination, aids in keeping its members up-to-date, improve curriculum development and services to the school-aged. The Council is becoming increasingly more involved with such areas as contents of vending machines, nutrition for athletes, etc.

A recent addition to the Office of Superintendent of Public Instruction is a Supervisor of Health and Physical Education. It was a disappointment that this person does not have a school health education background or primary interest in the area of school health education. Cooperation between the Department of Health and Office of Superintendent of School will be encouraged to the fullest to take advantage of the increased interest in school health on the part of communities, schools, and health personnel. With this increased interest, hopefully there will eventually be a full time School Health Supervisor in the Office of Superintendent of Public Instruction.

Consultation to local school boards and faculties continues. This consultation is provided by nursing consultants, health educators, nutritionists, sanitarians, public health physicians and others.

A booklet, Minimal Services for School Nursing, has been prepared by the Department's Nursing Staff to acquaint school administration, teacher, and school nurses with a minimal program on which interested school may build. (See appendix)

Public Health Nurses are continuously encouraged to find children with unidentified handicaps among the school-age populations and assist parents to get the children under care. Referrals to the Crippled Children's program are made by nurses and teachers through the regular channels. The addition of nurses employed by the Elementary and Secondary Educational Act and the Office of Economic Opportunity projects has increased the numbers of nurses serving the school-age population. Through a coordinated effort, many of these have sought leadership and guidance from the State Department of Health and Environmental Sciences, Division of Nursing. MCH Nursing Consultant is available to work with school nurses in establishing school health programs and expansion of school nurse role.

SECTION III. MATERNAL AND CHILD HEALTH AND CHILD HEALTH SERVICES (CCS)
PROGRAM SCOPE AND CONTENT

A. The MCH Program - Scope and Content (Continued)

3. School Health Program

c. Methods (Continued)

School health records are provided by the State Department of Health and Environmental Sciences and most of the schools use them. In the local schools, the records are kept in the Guidance Health Folders developed by the State Department of Public Instruction. The Montana School Health Curriculum Guide, a conceptual approach, was published in the Fall of 1974 and has been widely distributed among the schools.

Screening Programs in vision and hearing conservation are reported elsewhere in this Plan.

Montana State University now offers a degree in Health Education. The University of Montana and Eastern Montana College offer a degree in Health Education in connection with Physical Education and Recreation. Health Education consultants provide assistance regularly to health instruction classes at Montana State University, University of Montana and Eastern Montana College in Sexuality, Family Planning, V.D., and problems of additiona.

The Continuing Education Program in Public Health sponsored a seminar "School Health in Transition" which attracted school health teams from 19 communities. We will be following-up on this interest by assisting with consultation especially in the area of curriculum development.

Health Education has taken the leading role ir the development of Self Incorporated. A program that helps 11 - 13 year olds cope with emotional and social problems that confront them. We feel the program can be an important part of a School Health Education Program when used in a variety of learning situations.

Interest and attendance in school health education sessions at Regional meetings of the Office of Superintendent of Public Instruction held annually before opening of school doubled this year from the previous year. More schools are initiating health education courses and requesting help from health education consultants. Film library usage increased 23% in 1975 from 1974. The use of health films from the library has continually increased largely because more schools are using them.

SECTION III. MATERNAL AND CHILD HEALTH AND CHILD HEALTH SERVICES (CCS) PROGRAM SCOPE AND CONTENT

A. The MCH Program - Scope and Content (Continued)

3. School Health Program
c. Methods (Cont'd)

There was a marked increase in attendance and interest at the Advisory Council to the Joint Staff Committee between OSPI and SDHES. The Joint Staff Committee has exhibited renewed interest in total school health programs with most meetings this year attended by all members.

One health education consultant has been assigned almost full-time to the school health program. A supervisor of Health and Physical Education was employed by OSPI and although the supervisor has no health background, increased program effort and promotion is occurring with close cooperation and coordination between the two agencies.

Many schools in the State are developing a health education curriculum for grades kindergarten through high school. Public schools of Helena, when their work is completed, will be evaluated, and if it is as good as we anticipate, it will be used as a suggested model for other schools.

For 1974, 1975, and 1976 the OSPI received an 18 month grant from the U.S. Department of Agriculture - "A Demonstration Project Implementing a Comprehensive Elementary Nutrition Education Program in Conjunction with School Food Services Program and Integrated with other Curriculum Areas." This grant was the cooperative efforts of the Joint OSPI and SDHES Committee on Nutrition Education. A nutrition education specialist has been employed by OSPI to implement the nutrition curriculum developed into Montana elementary school system through teacher workshops, demonstration projects and compilation and distribution of nutrition education materials. Nutrition education will be a continuing emphasis of OSPI after the federal grant ends.

The High School Education for Parenthood-Family Life and/or Sex and Sexuality Education

This program continues in schools in the State as it was introduced several years ago with the public health nurses serving as the discussion leader in the unit on Family Life in Home Economics or in other subject matter areas.

In several schools the teachers have taken over this instruction with the public health nurse serving as the resource person. In other schools Family Life Programs have been developed and have incorporated this type of instruction into those programs; in others the program is developed as Sex and Sexuality Education. For the purpose of this plan State Department of Health participation will be described as a whole and not by the three types.

SECTION III. MATERNAL AND CHILD HEALTH AND CHILD HEALTH SERVICES (CCS) PROGRAM SCOPE AND CONTENT

A. The MCH Program - Scope and Content (Cont'd)

3. School Health Program

a. The Goal

The goal of the program is to provide information and the development of attitudes that will give high school students an understanding of "sexuality" as a part of their total development and not as something set apart. It is aimed to aid in preparing young people for parenthood and to reduce the number of teenage pregnancies. Schools are encouraged to provide education in sex and sexuality, conception, family planning, pregnancy, labor and delivery, and an introduction to the care of the infant and wherever possible, to include the principles of family planning.

b. Needs and Problems

Until the adaptation of the "Education for Parenthood" Program for adults to its use for high school students, there was practically nothing taught in these areas in the Montana schools. Although there is an increase in this type of education, there still remains much to be done.

Information from school officials and nurses working in schools indicates the continued increase in pregnancies in school age girls. An objective in the family planning education program is to investigate every possible means of decreasing teen-age pregnancies through working with teenagers, schools, parents, and community groups.

c. Methods

In the spring of 1965, personnel attended a meeting called by the State Department of Health and Environmental Sciences. They came from some of the schools where the Education for Parenthood Program had been initiated successfully with either nurses serving as discussion leaders for girls' groups or the the young men who had been trained at the University of Montana in a workshop sponsored by the University of Montana and the State Department of Health and Environmental Sciences with the State staff providing the instructors and conducting the workshop. This group recommended that more teachers be trained so they could become the discussion leaders. They recommended that the public health nurses serve as discussion leaders in the sections on labor and delivery and as resource persons to the teachers.

This recommendation is based on the educational principle that regular instruction should be the responsibility of the teaching staff if that staff has been trained, and that resource persons be brought in for special areas in which the teachers are not usually trained. This revised plan also frees the nurses for the activities that only a nurse can do and is, therefore, in line with the principle of utilizing

A. The MCH Program - Scope and Content (Cont'd)

3. School Health Program (Cont'd) c. Methods

others as "helpers" to the health professionals.

The Perinatal Educational Manual is available through the MCH Bureau, State Department of Health and Environmental Sciences.

When a school or PTA in an area indicates an interest in starting a program and makes a request for assistance to the State Department of Health and Environmental Sciences, the health educator meets with a planning group, usually composed of school and community personnel. At this meeting a report is given of the programs on-going in other schools, some of them have taken quite some time to get started but eventually have done so. Effort will be spent on attempting to find a new and innovative way to decrease teen pregnancies. Work will be done with personnel in family planning clinics, youth development workers, school guidance counselors, and others in providing resource for this study.

Measures of Progress

Progress can be measured by the increasing number of schools initiating and continuing sexuality and family life education programs. Requests for assistance increase which is another indication of interest. Our films in this area are in use constantly. Decrease in the number of teen pregnancies over the the next five years will be measured.

A program geared to helping parents talk with their children about sex and sexuality, reproduction, etc. will be continued and intensified.

4. Nutrition

a. Goals

To improve the nutrition status of mothers, infants and children through incorporation of nutrition services in maternal and child health programs.

b. Needs and Problems

Nutrition is a critical factor in the promotion of health and prevention of disease and in recovery and rehabilitation from illness or injury. Evidence mounts that Americans who fail to attain a diet optimal for health can be found at every socio-economic level. The reasons are many and complex, but the impact on the health of the nation is seen in:

---The increased risk of complications of pregnancy in the poorly nourished woman.
---The chance that her infant may be of low birth weight with accompanying risk of retarded physical and mental development.
---The high prevalence of overweight and underweight in school-age children and in adults.
---The high prevalence of iron deficiency anemia in infants, children and women of child-bearing age.
---Widespread dental diseases in the total population.
---The high prevalence of chronic illness requiring dietary treatment, monitoring and followup.

Improvements in the nutrition of people will have a direct effect on the level of health throughout the life cycle.

c. Methods

Any proposed system of health care must address itself to early identification and intervention of persons at nutritional risk. To date, national medical care policy has not responded to the synergistic relationships between nutrition and health. It has not provided the basic nutrition services which people need to assume responsibility for their own nutritional health.

Food and nutritional care are not synonymous. Nutritional care encompasses the services needed to apply the science of nutrition to the benefits of an

4. Nutrition (Con't)

individual's health status. A system of nutritional care includes the following essential services to meet individual and family needs:

---Assessment of nutritional status:
- Food availability and consumption information.
- Biochemical measurements of nutrients in body fluids and tissues.
- Clinical examination including assessment of growth utilizing anthropometric measurements.

---Planning and implementation of:
- Counseling to meet normal and therapeutic needs resulting in measurable behavioral changes.
- Nutrition information system responsive to consumer beliefs, attitudes, environmental influences, and understandings about food.
- Provision of, or referral to resources for an appropriate system of food assistance such as home delivered meals, community meals for the elderly, supplemental food programs for high risk groups such as pregnant women and infants, food stamps, child nutrition services (school feeding and child day care feeding).
- Recording pertinent data.

---Monitoring and evaluation:
- Periodical followup to evaluate the results and to adjust the plan of client care as needed.
- Establishing a review mechanism to evaluate the quality and utilization of nutritional care services.

These three items are essential if nutritional care is to be responsive to human needs.

d. Evaluation

Nutrition services in maternal and child care should target on identified key nutrition problems such as iron deficiency anemia, low birth weight infants, failure to thrive, and weight gain during pregnancy, etc. Measurable objectives express the expected decrease in the specific problem within a certain time period. Evaluation of the nutrition service will evolve around the accomplishment of the measurable objectives.

SECTION III. MATERNAL AND CHILD HEALTH AND CHILD HEALTH SERVICES (CCS) PROGRAM SCOPE AND CONTENT

A. The MCH Program - Scope and Content (Cont'd)

5. Preschool Vision Screening

a. Goal

The present goal of the preschool vision screening program is to assist community volunteers to continue their screening programs on a regular basis, either annually or bi-annually according to the most practical for their preschool population. Preschool vision screening identifies cases of suspected vision problems among children beginning at about age three and refers them for examination and treatment if a problem is suspected. Specifically, the program is aimed at identifying suspected "amblyopia ex anopsia," and to provide education for the parents. It aims to motivate parents to seek an examination and treatment if needed from any eye specialist.

b. Needs and Problems

It is important for children with amblyopia ex anopsia to get treatment by the time they are four and before they are six year of age in order that treatment can be effective. Until the State Department instituted this program, it was a condition about which parents, teacher, and the public knew little, if anything. Therefore, the conditions were not discovered until it was too late for correction. The map (see appendix) shows the number of counties conducting screening programs annually, biennially, those that are inactive, and one program sponsored by the Junior League and National Society for the Prevention of Blindness.

Intensified screening programs have been conducted in every county in the state, except for Yellowstone, with direct assistance from the Health Education staff. Each County was encouraged to continue regular screening programs with assistance in training new volunteers when necessary by SDH Health Education staff. There is continuing need to remind county committees to return reports which assists in keeping the program on-going. However, most committees are very active and the volunteers are most enthusiastic because of their participation.

c. Method

The "Community Organization" method is used which includes the formation of a steering committee, education, motivation and training of volunteers and record keepers.

SECTION III. MATERNAL AND CHILD HEALTH AND CHILD HEALTH SERVICES (CCS)
PROGRAM SCOPE AND CONTENT

A. The MCH Program - Scope and Content (Cont'd)

5. Preschool Vision Screening (Cont'd)

An education program for the steering committee, volunteers and community is an important aspect of the program. The volunteers are trained to administer the Snellen Test. Those children who do not pass the test satisfactorily are retested within two weeks. If there is a public health nurse in the community, she is present at the rescreening and can then begin her follow-up work to get the children under care. If there is no nurse, the parents are advised by the volunteers that an examination by an eye specialist (ophthalmologist or optometrist) is advisable.

The HOME EYE TEST, a kit developed by the National Society for the Prevention of Blindness, was promoted by the Health Education Bureau. The kit not only assisted parents in finding their youngsters' vision problems, but educates parents to the importance of early eye care.

d. Measures of Progress, Evaluation and Plans for Extension

The parents whose children are found to have vision problems after referral express appreciation for the efforts made by the State staff and the local program participants.

The program is well accepted by the eye specialists in the State.

Continued assistance will be provided by the Health Education staff. Community leaders will be encouraged to continue this screening program and report results.

SECTION III. MCH - CC PROGRAM - SCOPE AND CONTENT

6. Hearing Conservation

This is a joint program between the MCH Bureau and Preventive Health Services Bureau. It serves both adults and children. Assistance is given by the Health Education Bureau and Nursing Bureau.

a. Goal

The program is aimed to prevention and education, case-finding, treatment and rehabilitation, in preserving "hearing" and in the prevention of hearing handicaps.

Further, the development of services at the local and regional level will necessitate consultive/support and supervisory service from the hearing conservation program office.

b. Needs and Problems

From the screening and threshold testing carried out thus far, it has been found that approximately 3 percent of the children in Montana are referred for further examination. Many of their parents have not been aware of the seriousness of periodic earaches, draining ears and the handicap resulting from a loss of hearing.

The need for ear care and follow through to rehabilitation is not nearly as commonly accepted as is that of those handicapped by vision problems.

Another problem which is receiving increasing attention is the potential danger of excessive noise exposure to the hearing mechanism. In a recent hearing conservation program, 32 percent of the senior high school students and 18 percent of the junior high school and grade school students screened demonstrated varying degrees of high frequency loss--typical of the type related to noise exposure. The majority (69 percent) of the senior and junior high school students were males who shoot guns or drive heavy machinery, both common activities in this state. A small percentage also played in a modern musical rock group.

The special project on the Blackfeet Indian Reservation (Browning) indicates the lack of medical attention that has been given to ear infections over many years. If this is the condition on the other Indian reservations, and there are six of them, the problem may be insurmountable

6. Hearing Conservation (Con't)

unless the Division of Indian Health can secure funds and staff to cope with this problem.

There is still a need to interest more of the family physicians in the state in making referrals for audiological testing and referral to medical specialists. However, the limited number of medical specialists also presents severe problems as some of the family physicians feel the waiting list is so long that referral is useless.

The chief administrative problem is the lack of staff to carry out the program statewide.

c. Method

Program planning is done by the multi-discipline team that participates in the program. Further input is received and coordination efforts planned by now existing regional audiological programs.

1. County-wide Hearing Conservation Program

The general plan for a county-wide conservation of hearing program is based on the experience we have had in carrying out the program for children and adults simultaneously.

The staff planning and evaluation is based on the "Planning, Evaluation and Review Technique" (PERT). This includes planning and developing the community organization, establishing a steering committee, organizing committees on education, publicity, schedule and site selection, securing volunteers and arranging for their training and evaluation committee. This is a health education consultant volunteer to conduct the screening tests.

The audiologist is present in the community during the actual screening and thus is able to carry out much of the threshold testing immediately.

Following the threshold testing by the audiologist, the child with a suspected hearing loss is either referred to his family physician for a medical examination and from there to an otolaryngologist or otologist, or he is seen for further audiological evaluation by the department's audiologist or regional audiologist and then referred to the family physician.

Children who need and are eligible are provided with care under the Cripped Children's Program, which is described in Section in this part of the plan.

6. Hearing Conservation (Con't)

2. Clinical Evaluations

Clinical evaluations are made on physician and/or other professional referral and range from simple clinic hearing tests to hearing aid evaluations and fitting, counseling and followup care and advice.

3. Consultation and Organizational Services Are Also Provided

Included in this part of the program are in-service training for staff at the School for the Deaf and Blind, consultation to the deaf education program at the Boulder River School and Hospital--the state school for the retarded, assistance to the PHS Division of Indian Health--providing care for their patients, etc.

d. Measure of Progress, Evaluation and Plans for Extension

Until the employment of audiologists in 1965, the only parts of the program for children that the Montana Department of Health and Environmental Sciences provided was a limited amount of screening with followup by the public health nurse, with referral to care. With the addition of the audiologists the program was vastly improved with their abilities to do definitive testing and counseling.

Services for children with hearing handicaps have been included in the Crippled Children's Program which has greatly improved the conservation of hearing program, particularly its results.

When the health educators began to participate, the education and prevention parts of the children's program were stepped up.

Within the past year, two articles related to the dangers of excessive noise exposure have been printed in the Montana Department of Health and Environmental Sciences' official bulletin, "Treasure State Health." Adults who work in noisy occupations are counseled by the audiologists when threshold tests are given relative to the wearing of ear protection devices and the health educators bring it to the attention of adults in the education programs they conduct. These efforts have resulted in the public gradually becoming more aware of the problem. A number of requests have come into the department asking where protective devices are available, since emphasis has been placed on noise as a hearing hazard.

The number of requests now being received would indicate that the department's Hearing Conservation Program will be required to participate in noise reduction and industrial

6. Hearing Conservation (Con't)

hearing conservation programs. Such programs would involve testing as well as industrial hearing conservation program consulting.

e. Interest of Other Agencies

Relative to the administrative lack of staff described in section (6)(b), the present coordinator has undertaken to interest other agencies regarding the creation of audiological programs to serve their immediate consumer population. Considering the magnitude of need for the pre-school and school-age population, the response from the Office of Superintendent of Public Instruction has helped considerably. To this end, there now exists (September, 1975) eleven regional audiological facilities with proper instrumentation and personnel to insure yearly coverage of the pre-school and school-age population. Such expansion has involved considerable funding from agencies other than this department. Nonetheless, the responsibility for overall observation, supervision and coordination falls on the coordinator of the Montana Department of Health and Environmental Sciences Hearing Conservation Program.

Such expansion of audiological service on the county and regional level has made less the demand for direct screening and testing programs offered by this office. In this regard, the role and view of the department Hearing Conservation Program and its coordinator has changed from trying to offer a direct service statewide to that of consultant and statewide coordinator of services now available.

f. Department of Social and Rehabilitation Services

Due to the expansion of services mentioned in part (e) of section (6) and thereby a considerable increase in referrals and inasmuch as the Rehabilitative Services Division and the Economic Assistance Division of the Department of Social and Rehabilitation Services have expanded their financial and professional service to the hearing impaired, a quality control checkpoint became necessary. To this end, the coordinator of the Department of Health and Environmental Sciences Hearing Conservation Program has been contracted by both the Rehabilitative Services Division and Economic Assistance Division of the Department of Social and Rehabilitation Services to review all audiological facilities in order to assure adequacy of instrumentation and competency of personnel and further to review all cases requiring any expenditure of state monies. Again, these contracts and the supervision, inspection, and review required, as well as the need of the various audiological facilities for this state level consultive support have changed the role of the Montana

6. Hearing Conservation (Con't)

Department of Health and Environmental Sciences Hearing Conservation Program. Although the formerly described direct service is still available from this office, it is needed, in general, only in those remote areas not reached by now existing regional programs. Direction, coordination, quality control, and accountability for existing programs now are viewed as priorities for this department's Hearing Conservation Program.

Other Services

Because college and other school staffs, industry, local public health and other professional persons need to be alerted to the conservation of hearing program, casefinding and referral, it was planned to conduct workshops for in-service training during the 1975-76 school year.

The department staff will organize and staff the workshops with medical specialists asked to assist in instruction. There will be four to six such workshops, each in a different area of the state. The places will be selected to provide an opportunity for reaching the greatest number of persons needing this training.

Evaluation

The evaluation of the hearing conservation program will be made by:

---The continuing requests for programs from local groups.

---The increase in referrals for clinical evaluations from the physicians.

---The increased general awareness of hazards to hearing and steps taken to eliminate or reduce them wherever possible.

---Improved education in the schools and community.

---An improved acceptance in the use of hearing aids.

---Increased interest in descresing the "noise" problem.

SECTION III. MATERNAL AND CHILD HEALTH AND CHILD HEALTH SERVICES (CCS) PROGRAM SCOPE AND CONTENT (Con't)

A. THE MCH PROGRAM - Scope and Content (Con't)

7. Social Services

a. Goal

To develop social service programs as an integral part of the health care system to improve family health in Montana. When financial crisis and emotional stress are added to a medical based crisis, a family can often be thrown into a state of turmoil and unable to cope with their situation. The individual patient usually suffers from some personal turmoil due to hospitalization, surgery, separation from family and, in some instances, changes in physical abilities. When the individual is unable to express his feelings and deal with his emotions and his family is struggling in a similar way with their emotions and concerns, then there is a need for intervention in order to alleviate some stress so the situation is manageable. This situation can also interfere with the ability to utilize the medical resources which may have various effects on the medical problem. For example, certain health care instructions are given to the patient; the patient is then sent home, and within two days he returns to the health care facility because the situation has worsened. What went wrong everyone asks. Not very often does the health care system say "Let's look at the home and see what's happening in the interpersonal relationship arena to determine if any of these problems are affecting ability to follow the medical instruction."

b. Methodology

The social worker in the Maternal and Child Health Bureau will be responsible for the continued development of social services where appropriate to the health care systems. The intent is to broaden the scope of health care to include assisting clients with problems in interpersonal relationship, financial situations, and their environment which may interfere with recovery and rehabilitation. As a consultant to local programs, the social worker is reponsible for technical assistance in assuring quality social work services are provided in the project. The consultant needs to be able to offer assistance in the local assessment of needs, prioritizing those needs, and determining a feasible way of delivering those needed services. This also is an excellent time to help projects broaden their approach to identify problems and offer a more conclusive range of services

A. THE MCH PROGRAM - Scope and Content (Con't)

7. Social Services (Con't)

b. Methodology (Con't)

which can help to insure the client's ability to utilize the available resources.

When appropriate, the Maternal and Child Health Services Bureau social worker may offer limited supervision of a project social worker. The supervision will be focused on the expertise of the social work practitioner in delivering high quality care. When a problem is discovered in the area of methodology, then the consultant shall work with the project director and the project social worker to resolve the situation. The responsibility of the program and staff management remains with the project director, but the social work consultant is ultimately responsible for the inclusion of social services in the project and the assurance the services are of high quality and meeting the needs of the clientele.

The social worker may provide diagnostic evaluation for the various cleft palate teams during clinic session. However, the primary role with the cleft palate program is to coordinate and refer families to local resources and receive followup reports regarding those services. The social worker acts as a liaison between the team members, local health care personnel, the family and other appropriate professionals who may be working with the family or child.

Since the social worker is employed by an agency which offers services for the entire state, it is not practical to provide direct services to a selected caseload. As the Child Health Services program is able to demonstrate the need and develop a localized social service for clients in need of this service, then direct services become a feasible mode of treatment. The state social work staff would remain in the primary role as consultants, supervisors, and planners for programs.

A. THE MCH PROGRAM - Scope and Content (Con't)

8. Screening of Newborns

a. Goal

To test all newborns in Montana for errors of metabolism to assure that children born with phenylketonuria, tyrosinemia, galactosemia, maple syrup urine disease, homocystinuria, and hypothyroidism are identified and brought under early treatment so that by the age of six years, they would demonstrate a distribution of growth and development achievement equal to that of the total population of six year olds. To provide appropriate consultation to those responsible for the treatment of cases of these diseases.

b. Needs and Problems

If these conditions are not detected early in life and treated promptly, severe mental retardation or even death may be the result. Recognizing the need for an organized effort in approaching this problem, the legislature, in its 1973 session, enacted into law a bill requiring tests for inborn errors of metabolism on all infants born in the state of Montana: Section 69-6710 through 69-6713, R.C.M. 1947, INFANT SCREENING TESTS: Montana Administrative Codes 16-2.14(6)-S1820.

To set up a complete metabolic screening laboratory for an estimated 12,000 live births per year in Montana would be inefficient and impractical. Therefore, we have contracted with the state of Oregon, through the Oregon Metabolic Disorders Screening Program to test specimens from Montana along with theirs and to provide some consultation from Dr. Buist's Metabolic Disorders Clinic at the University of Oregon Health Sciences Center.

A problem which is not solved is screening for the mucopolysaccharidoses. Pathologists are being encouraged to do this in their own laboratories.

c. Method

Testing kits are provided by us to all hospitals with maternity services and to others on request. Our policy calls for collection of blood spots prior to discharge of the newborn. We also recommend a four to six-week

A. THE MCH PROGRAM - Scope and Content (Con't)

8. Screening of Newborns (Con't)

c. Method (Con't)

followup specimen because new tests are being developed which may yield better results on these samples. Specimens are sent from the hospital directly to Oregon in in pre-addressed envelopes. Results are sent to us, and we report them to the hospital, clinic, or physician. Abnormal findings are reported by telephone to the physician and, when indicated, Dr. Buist offers consultation.

In most of these conditions, specific nutritional management is the major emphasis in treatment. The nutritionist with the Maternal and Child Health Bureau is responsible for providing consultation and follow-along for parents of infants with an aminoacidopathy or other deficiency. Special infant formulas, often relatively costly, may be provided through the Maternal and Child Health Bureau. They are essential in the nutritional management of these diseases.

Nursing consultation for parents of these cases is available through consultant staff of the Bureau of Nursing. Copies of reports are sent to this bureau for checking against birth records so those infants who missed being tested can be followed up.

d. Measure of Progress, Evaluation and Plans for Extension

Success of the program will be gauged by the degree to which cases of inborn errors of metabolism are detected by infant screening tests. Consideration should be given to making cases of inborn errors of metabolism reportable to the department so a more adequate evaluation of the program can be made. This would also provide a greater opportunity for offering services from the concerned bureaus.

Genetic counseling should be more readily available in Montana, particularly to residents of rural areas. We will lend our efforts to promoting this.

The Advisory Committee on Infant Screening of the Maternal and Child Health Bureau will meet annually in Helena sometime during the month of July. One of their functions will be evaluation of the program.

SECTION III. MATERNAL AND CHILD HEALTH AND CHILD HEALTH SERVICES (CCS) PROGRAM SCOPE AND CONTENT (Con't)

A. THE MCH PROGRAM - Scope and Content (Con't)

8. Screening of Newborns (Con't)

d. Measure of Progress, Evaluation and Plans for Extension (Con't)

Note: A proposal to charge a fee of $4.00 per specimen to cover costs of the infant screening program was scheduled for discussion at the October 3, 1975, meeting of the Board of Health and Environmental Sciences but other hearings crowded the agenda. However, John Newman, M.D., a member of the board, commented that the department should not charge for a test required by law. This also is the policy of the department. In one section of the venereal disease law, there is the statement, "On request the department shall make laboratory tests required by this chapter without charge." However, when legislation is enacted requiring specific services and provision is not made for financing them, we are placed in a difficult position. A public hearing will be held on this question in line with the statute "providing guidelines for citizen participation in the operations of government agencies."

SECTION III. MATERNAL AND CHILD HEALTH AND CHILD HEALTH SERVICES (CCS) PROGRAM SCOPE AND CONTENT

A. The MCH Program - Scope and Content (Cont'd)

9. Dental Health

The Bureau of Dental Health, in conjunction with the Montana State Dental Association, establishes and maintains programs which promote optimal dental health of the citizens of the State.

Problems

Problems associated with oral disease are as yet far from being resolved in this State. Surveys of various communities show high levels of dental health needs including dental caries, periodontal disease, malocclusion, cleft palate and others. The high incidence of dental caries remains as the major problem.

The ratio of dentists to population in Montana is about the same as it is for the nation: one dentist to two-thousand people. The basic problem is distribution of dental manpower within the State. A disproportionately high percent of dentists are located in population centers of the western part of the State. Prospects of rural counties, most of which are in the eastern and north central part of Montana, for obtaining dental services, are not encouraging.

There is a need, also, to provide dental service for those segments of the population unable, for financial reasons, to provide dental services for themselves. Extensive care is required for persons in age groups one to twenty and sixty-five and over who are in many cases dependent on others for total or partial support. There is a definite need for con inuing expanding dental health education programs among the practicing dentists and auxiliary personnel, physicians, nurses, and the general population of school personnel including colleges and schools of nursing.

a. Objective

The objective of the program is to reduce dental disease in the general population through programs of education, prevention, research and services.

b. Methods

1. Preventive Programs
Fluoridation of Public Water Supplies -- Control of dental caries shall be provided by promoting controlled fluoridation of community water supplies by providing educational materials, assistance with community organization, free analysis of natural fluoride content

A. The MCH Program - Scope and Content (Cont'd)

9. Dental Health (continued)

of water supplies, and consultation in purchasing and installing fluoridation equipment.

Fourteen communities and/or State institutions have fluoridated their water supplies in the last seven years through an Equipment Grant Program. In this program fluoridation equipment is provided to communities on a permanent loan basis as long as the community keeps it in operation. Local, state, and federal funds will be sought to make continuance of this program possible.

As a substitute for water fluoridation, information will be provided on request to physicans and dentists on dietary supplements in the form of tablets, drugs or vitamin additions.

School Preventive Dentistry Program

Need -- The two most prevalent dental diseases, dental caries and periodontia (gum diseases), afflict almost 100% of the population in Montana as well as the rest of the United States. A large part of these diseases can be prevented by application of preventive procedures that improve oral hygiene. Establishing a habit of proper oral hygiene early in life will serve to protect Montana school children against dental disease throughout their lifetime.

Goal -- To improve the oral hygiene and thus, the dental health of Montana school children.

a. Objective

1. To provide Montana elementary school children with a dental health education program that will include a lecture on cause and effect of dental disease, nutritional advice, and a method of controlling their own dental disease through plaque removal.

2. To provide each elementary school child a toothbrush annually and demonstrate an accepted, effective way of using it for removal of dental plaque.

b. Activities

1. Submit an appropriation bill to Montana legislature to fund employment of two dental hygienists, purchase of all supplies necessary to program, and travel expenses for hygienists.

A. The MCH Program - Scope and Content (Cont'd)

9. Dental Health (Cont'd)

2. Train dental hygienists in dental health education lectures and demonstration of plaque removal techniques.

3. Make each hygienist responsible for implementing the program for approximately 55,000 school children in about half of the State. Elementary school population is about 110,000.

Evaluation -- A before and after Personal Hygiene Performance Index will be accomplished on a study group of children to to determine effectiveness of program.

Statewide Coverage of Program -- The plan for this program was to carry it statewide by July, 1975. The Montana legislature turned down the appropriation bill submitted to cover funding for the program. Available funds permitted the use of an alternate plan, employing a dental health educator and using volunteers to provide program services to in excess of 50,000 Montana school children.

Fluoride Mouth Rinse Program -- The most promising method to provide the benefits of fluoride for the reduction of dental caries to children who live in communities with non-fluoridated water supplies that is available at present is rinsing the oral cavity one a week during the school year with a 0.2% fluoride mouth rinse. Not only can a reduction in dental decay of 20% to 50% be expected, but the program involves a large number of volunteers from parent organizations and teachers who get a realistic exposure to preventive dental health.

The Bureau of Dental Health in cooperation with the Council on Dental Health of the Montana Dental Association has developed a set of guidelines to assist communities in implementing Fluoride Mouth Rinse Programs statewide. Members of the Council on Dental Health will promote and initiate Fluoride Mouth Rinse Programs at the local level. The Bureau of Dental Health will assist the council members and keep a record of the Fluoride Mouth Rinse Programs as they develop.

Dental Referral Card Program -- This program is being phased out because of lack of interest of school administrators in distribution and reporting. Cards will be provided to schools and school systems only by request.

A. THE MCH Program - Scope and Content (Cont'd)

9. Dental Health (Cont'd)

Vending Machine Policy -- The Bureau of Dental Health in cooperation with the Council on Dental Health of the Montana Dental Association has developed a policy on School Vending Machines that in essence states vending machines should be removed from the schools or foods with identified nutritional value be substituted in the machines for the sugar non-foods usually dispensed. The Bureau of Dental Health will cooperate with the Department of Public Instruction to promote adoption of this policy in the Montana schools.

c. Service Programs

1. The Bureau of Dental Health is giving assistance to many communities who are now providing dental care to children in segments of the underprivleged population through consultation and evaluation. Many Head Start Programs are in operation throughout the State, most of which include some dental services. The Children and Youth Project in Lewis and Clark County provides dental services to a wide area of children in the low average income group. The Cascade City-County Health Department employs a full-time dentist who provides some dental care to children unable to get it otheriwise, and does screening diagnosis and treatment planning for children's dental care programs in this locality. Title XIX Medicaid provides dental care to all eligible recipients in Montana.

2. Flathead County Children's Dental Health Project -- Under the dental care portion of this project, comprehensive dental care is provided by the dentist of their choice to elementary school children from medically indigent families. Under the school preventive dentistry portion, the project hygienist provides screening, dental health education, and plaque control demonstrations. The project hygienist also supervises a Fluoride Mouth Rinse Project in the school system.

Statewide Need

Children from medically indigent families in Montana have no access to dental care except through the Flathead County Children's Dental Health Project, the Lewis and Clark County Child and Youth Project, and Title XIX Medicaid benefits. On July 1, 1975, all benefits for the medically indigent will be dropped from the Title XIX Medicaid Program. This leaves just the two county programs available to provide dental care benefits.

A. The MCH Program - Scope and Content (Cont'd)

9. Dental Health (Cont'd)

The need for dental care benefits, preventive services, and dental health education provided by the Flathead County Children's Dental Health Project is universal in Montana for children of medically indigent families. As funds become available, planning must be accomplished to provide these services statewide.

Assurances

The program of projects will provide services particularly in areas with concentrations of low-income families, with priority given to the areas having the greatest need for such services, whether urban or rural.

Diagnostic, screening, and preventive services will be available without charge to all children within the area served by the program of projects.

Treatment, correction of defects, or aftercare will be available only to children who otherwise would not receive such services because they are from low-income families or for other reasons beyond their control.

Services will be available to children from outside the area served by the project only if it is determined by the project director that provision of such services will best promote the purposes of the program of projects under this section.

Treatment, correction of defects, and aftercare will be provided to children and youth who are not from low-income families but who would not otherwise receive such services for reasons beyond their control only if such treatment does not reduce the delivery of necessary services to children from low-income families. In those instances where charges are made for treatment services provided to children who are not from low-income families, such charges shall be applied flexibly with due regard to family size and income and the family's other financial responsibilities in relation to the cost of required care. Full disclosure of such payment scales and the factors by which they are applied shall be made available to the providers as well as to the patients and their families. The established basic payment schedule shall not exceed actual costs. Every reasonable effort will be made to collect from third-party payment sources (including Government agencies) which are authorized or under legal obligation to make such payments. Where the cost of care and services furnished by or through the program of projects is to be reimbursed by a Government agency, a written agreement with that agency is required. Reimbursement may be made either to the project or directly to the provider, in accordance with such agreement.

9. Dental Health(Cont'd)

The Program of projects will be administered by the State Maternal and Child Health Program unit, either directly or through grants or contracts. The Dental Bureau of the State Department of Health and Environmental Sciences will have direct responsibility for the Flathead County Children's Dental Health Project. The Chief of the Dental Bureau will act as project director.

Dental care and services provided by the project will be under the direction and responsibility of dentists with appropriate training and experience.

Determinations of eligibility for services under the project will be made by the project director or a member of the project staff designated by him and will be in accordance with the Act, these regulations and the policies and procedures promulgated thereunder, and in accordance with the approved State plan.

To the extent that funds are inadequate for the provision of comprehensive dental care and services, the program of projects will be curtailed in terms of areas served or age levels of children served, or similar factors, and not in terms of the care and services provided under the program.

The program of projects will be in addition to the demonstration services referred to previously.

Billings Emergency Dental Care Program -- The Bureau of Dental Health has trained Billings school nurses in dental screening with the purpose of screening annually to identify children in need of emergent dental care in the Title I schools. The Advisory Committee to this program has requested the Billings school system to make additional Title I, E.S.E.A funds available to satisfy the need for emergent care in the schools.

Consultant Dental Services and Oral Hygiene Care for Patients in Long-Term Care Facilities -- The Bureau of Dental Health is developing (1) guidelines on the role of an advisory dentist to a long-term care facility and (2) a manual on "Oral Hygiene Care for Long-Term Care Facilities" to be used as a reference for developing in-service training programs and as resource material for the staff of the facilities to provide oral hygiene care for patients.

The Bureau of Dental Health provides assistance to the Department's "Cleft Lip and Palate Program." This Program provides team evaluation and care without charge. There are four teams in the State - Billings, Great Falls, Helena, and Missoula. Care for children eligible under the Crippled Children's Program is provided by the State Department of Health and Environmental Sciences.

SECTION III. MATERNAL AND CHILD HEALTH AND CHILD HEALTH SERVICES (CCS)
PROGRAM SCOPE AND CONTENT

A. The MCH Program - Scope and Content (Cont'd)

9. Dental Health (Cont'd)

Education

School and Public Education in Dental Health -- The Dental Health Education program is carried out with the assistance of the Division of Health Education. The preventive and service programs previously described, each have an education component.

Cooperation will be continued with the Department of Public Instruction in the units of the Universities and Colleges which have teacher training programs in an effort to improve dental health instruction. Private Teachers Colleges are also eligible for these programs.

In-Service training in dental health education is provided for local school faculties. Programs at PTA meetings, civic clubs, etc., are promoted. Workshops for teachers and dental health educational materials will be provided on request.

Education programs aimed to encourage persons to place themselves under continuous dental supervision will continue.

Training for EPSDT Screening -- The Chief of the Dental Bureau continues to conduct training courses for all team members on the Early Screening for Prevention, Diagnosis and Treatment Program, a program Title XIX Medicaid contracted with the State Department of Health and Environmental Sciences to accomplish. He also conducts training sessions for public health nurses in counties capable of forming their own screening teams.

Carroll College Dental Hygiene School -- The Bureau of Dental Health over the past four years has given strong support to the development and initiation of the Dental Hygiene Program at Carroll College. The Dental Hygiene School is off and running with its first capping ceremony this year. The Chief of the Bureau of Dental Health continues to serve on the Advisory Committee and act as Consultant to the School.

Research

Dental Manpower Survey -- The Bureau of Dental Health joined with the Department of Business and Occupational Licensing to complete the first Dental Manpower Survey for Montana. The Department of Business and Occupational Licensing sent survey forms out with the dental license renewal forms to all dentists practicing in Montana. The Bureau of Dental Health gathered the information from the returned forms with all but one dentist in the State responding. Now available are up to date lists of all dentists both alphabetically

A. The MCH Program - Scope and Content (Cont'd)

Research

and by city; a list of all specialty and limited practices; a profile of the practice of dentistry in Montana; a profile of the practice of Dental Hygiene in Montana; the location and number of days worked by all practicing Dental Hygienists; dental manpower shortage areas; and position openings for Dental Hygienists, Dental Assistants, and Dental Laboratory Technicians. Plans call for updating the results of this survey on a continuing basis.

Anaconda Fluoride Mouth Rinse Program -- The Bureau of Dental Health has entered into a contract to cooperate with the National Caries Prevention Program, National Institute of Dental Research, National Institute of Health, to do a cost benefit analysis of a Fluoride Mouth Rinse Program and a reduction in caries increment provided by the rinse in Anaconda, Montana, for a period of 4.7 years. Upon completion, results of these studies will be used to promote the prgram statewide.

SECTION III. . COMMUNICABLE DISEASE FIELD SERVICES

A. The MCH Program - Scope and Content

10. 1. Introduction

The Preventive Health Services Bureau of the Montana Department of Health and Environmental Sciences has the responsibility for all immunization activities, venereal disease control, tuberculosis control, and the eipidemiological surveillance and/or followup of all communicable diseases in Montana.

The coordinator of the venereal disease and community vaccination programs and the coordinator of the tuberculosis control program serve under the direction of the chief of the Preventive Health Services Bureau. There are field health officers assigned to four districts, and they are responsible for all communicable disease services and activities in their respective areas. An Epidemic Intelligence Service (EIS) physician directs epidemiological investigations and disease surveillance.

2. Background

Only six of Montana's 56 counties presently have full-time health departments--Missoula, Cascade, Yellowstone, Flathead, Lewis and Clark, and Gallatin--but these health departments serve a population of 338,140 or 49 percent of the total population (1970 census). Forty-three counties have public health or school nurses, so 13 counties are without public health or school health nurses. There are a total of 102 public health nurses in Montana.

Scheduled immunization clinics are held in 21 counties. There are presently only six venereal disease clinics in Montana, but family planning clinics throughout the state screen female patients for gonorrhea and syphilis.

Montana has a "permissive" rather than compulsory immunization law for school enterers. The law states that local school districts are authorized to require adequate immunization status for school enterers.

A survey was conducted to determine the immunization status of first graders enrolled during the 1973-74 school year. The statewide results are as follows:

	% Adequately Immunized
DPT	58
Polio	58
Measles	74
Rubella	55
Mumps	27

2. Background (Con't)

The above results probably do not accurately reflect the true immunization status of these first graders; the school health record from which the information was obtained was obsolete and incomplete. For this reason, no school enterers immunization survey was conducted during the 1974-75 school year. The school health record has now been reviewed, and a school survey will be conducted during the 1975-76 school year.

A survey was conducted in 1974 to determine the immunization status of children born in Montana in 1972. The results are as follows:

	% Adequately Immunized
DPT	78
Polio	70
Measles	81
Rubella	79
Mumps	53

The following are some selected venereal disease statistics:

No. Civilian Gonorrhea Cases

1970	641
1971	1,121
1972	1,368
1973	1,658
1974	1,965

Gonorrhea Screening
July - December, 1974

	No. Cultures Performed	No. Positive	% Positive
Family Planning	3,440	75	2.2
Private Physicians	5,250	454	8.6
Indian Health	2,654	174	6.6
V.D. Clinics	636	126	19.8
Student Health	830	26	3.1
TOTAL	12,810	855	6.7

3. Community Vaccination Program (Short-term Objectives)

a. Assess the immunization levels of two-year old children.

b. Conduct a survey of the immunization levels of school enterers.

c. Reduce the number of reported measles by 95 percent.

d. Raise the level of protection for poliomyelitis by 15 percent in the pre-school population.

e. Design and implement a system for identifying and immunizing children enrolled in day-care centers.

f. Plan and conduct a coordinated public information and vaccine delivery program directed specifically at pre-schoolers.

g. Fully develop outbreak control guidelines and capabilities which will assure appropriate and rapid response to reports of immunizable disease occurrence.

4. Venereal Disease Program (Short-term Objectives)

a. Increase from 58 percent to 60 percent the number of public male gonorrhea patients interviewed by the venereal disease clinic and field staff.

b. Insure prompt and adequate treatment for 90 percent of the females found culture positive through screening activities.

c. Provide test-of-cure services for 60 percent of the culture positive females treated for gonorrhea through public clinics.

d. Interview all early syphilis cases within 48 hours of the confirmed report and re-interview 100 percent of these.

e. Maintain early syphilis morbidity at no greater than the present level.

f. Provide training to all Indian Health Service, local health department, and family planning nurses involved in venereal disease control.

g. Stimulate the implementation of venereal disease education as an integral part of school health curricula in 75 percent of the high schools in Montana.

4. Venereal Disease Program (Short-term Objectives) (Con't)

h. Provide a toll-free venereal disease hotline telephone service for Montana.

5. Evaluation

The achievement of objectives will be primarily evaluated through the following indicators:

a. Laboratory screening.

b. Morbidity reports.

c. Assessment of immunization levels.

d. Identification of outbreaks.

SECTION III. MATERNAL AND CHILD HEALTH AND CHILD HEALTH SERVICES (CCS) PROGRAM SCOPE AND CONTENT (Cont'd)

A. The MCH PROGRAM - Scope and Content

11. Nursing

a. Goal

To improve the health of mothers and children.

b. Methods

1. The MCH Nursing Consultant provides consultation to local health departments, hospitals, and other agencies upon request.

2. Promotes and assists in establishing Well Child Conferences throughout the State.

3. Instructs local nurses to provide perinatal education classes.

4. Encourages local nurses to teach growth and development classes to parents. Manual needed for sessions.

5. Encourages the development of maternity nursing conferences.

6. Conducts workshops on pediatric physical assessment.

7. Conducts workshop in all other areas of Maternal Child Nursing upon request.

8. Provides nursing consultation to WIC Program.

SECTION III. MATERNAL AND CHILD HEALTH AND CHILD HEALTH SERVICES (CCS) PROGRAM SCOPE AND CONTENT (Con't)

A. THE MCH PROGRAM - Scope and Content (Con't)

12. Family Health Nursing Services

a. Goals

---To get as many young families as possible under continuing medical supervision.

---To find cases of deviant development early in infancy and to bring these to medical treatment.

---To provide public health nursing services to young parents as they rear their children.

---To establish at least two new well-child conferences locally each year until the state is covered.

---To report severity of conditions found in well-child conferences (see appendix).

b. Needs and Problems

---Recruitment of qualified nursing staff at salary scales presently in effect in most local areas.

---An insufficient number of budgeted positions to provide high quality services to young families in all parts of Montana.

---Large geographic areas with sparse population.

---Long distances to travel.

---Another nurse consultant must be employed.

c. Methods

In their family health services, public health nurses are involved in most of the health programs providing services to families (including those services reported elsewhere in this plan). Nurses, being the most available of all public health professionals, serve a coordinating function between official and voluntary agencies providing services to mothers and their children. This function is strengthened by nursing consultants as they visit local nurses as well as by all in-service efforts, field placements for student nurses, etc.

A. The MCH PROGRAM - Scope and Content (Con't)

12. Family Health Nursing Services (Con't)

c. Methods (Con't)

Nursing consultants assist local boards with budgeting adequate amounts to enable them to assume a competitive position on the public health nurse labor market. Montana has a long way to go before public health nurse staffing can be considered adequate. One public health nurse might adequately serve all the people in two large counties if they were concentrated in a small area. Ratios of nurses to population become meaningless, however, when as few as 3,000 people live in a 6,000 square mile area. Most county boards have begun to ask the State Department of Health and Environmental Sciences for help in recruitment of public health nurses.

Public health nurses in all parts of the state have been instructed in the use of tools for the assessment of growth and development in infants and young children. This method has surpassed any so far used in promoting early identification of the handicapped child. Continuing promotion of the assessment method will be an on-going part of the supervision function of all nursing consultants on the state staff.

Public health, hospital and office nurses have had instruction at the primary level in physical assessment of adults and children. Followup workshops in physical assessment will be continued throughout the state upon request from local areas.

Maternal and child health conferences, as well as maternal and child health nursing conferences continue on a regularly scheduled basis in the Maternal and Child Nursing Project, Billings; Family Service Center, Butte; and the following city-county health departments: Missoula and Cascade; in Big Horn County in conjunction with the Indian Health Service. Well-child conferences have been established recently or will be established in the next year in the following areas: Miles City, Kalispell, Libby, Seeley Lake, Polson, Sidney, and Glasgow. The Children and Youth Project in Lewis and Clark County provides team evaluations in a clinic setting.

SECTION III. MATERNAL AND CHILD HEALTH AND CHILD HEALTH SERVICES (CCS) PROGRAM SCOPE AND CONTENT (Con't)

A. The MCH PROGRAM - Scope and Content (Con't)

12. Family Health Nursing Services (Con't)

c. Methods (Con't)

Sessions with students on nursing assessment of infants and pre-school children have been conducted at all divisions of the School of Nursing of Montana State University as well as all diploma schools.

The maternal and child health consultant will assist faculty from all schools of nursing in the state upon request in developing their skills and techniques in the total assessment of infants and children.

Hospital and office nurses and public health nurses alike need continuing education or a refresher course in dealing with maternity patients and newborns. Too many nurses feel they have nothing to offer, especially to the apparently normal.

Nine nurses are employed under a special project sponsored by the Old West Commission in eastern Montana who provide some maternal and child care to individuals within their respective localities.

A followup maternity workshop will be offered in May, 1976, for more in-depth preparation to nurses, a total of 160, who attended past maternity workshops. The initial followup maternity workshop will continue to be offered annually if the need arises.

d. Measures of Progress, Evaluations and Plans for Extension

Evaluation of family services can be based on the quality of practitioners who can hopefully be recruited. Adequate staff is the first consideration. In a five-year period with increased staff and with better preparation of all nurses, there should be few children entering school with uncorrected defects.

Family Planning is referenced at this point to the State-Wide Plan located in Section V.

SECTION III. B. THE CHILD HEALTH SERVICES PROGRAM - SCOPE AND CONTENT

1. Introduction

Crippled Children's Services was changed to Child Health Services to reduce the unnecessary confusion that exists in the state. Many people have confused this Crippled Children's Services with Easter Seal Centers for Crippled Children and Adults, Shodair Crippled Children's Hospital, and Missoula's Crippled Children's and Adults' Rehabilitation Center.

2. Purpose

The purpose of Child Health Services is to identify children as early as possible who have handicapping conditions and to assure the provision of adequate medical, surgical, dental, social, emotional, nutritional, health education, and rehabilitative services for those children under 21 years of age who are eligible for program services. Through these program efforts, each child will have the opportunity to develop physically, mentally, and socially to the maximum of his potential.

3. Objectives

a. Promote early casefinding so that services to children can be given at the optimum time.

b. Maintain, promote, and develop facilities for the diagnosis and treatment of handicapping conditions.

c. Offer consultation service to other agencies and groups in the social work, audiology, speech nursing, medical, and health education, as well as financial help.

d. Provide coounseling to families with handicapped children.

e. Maintain quality control and promote high standards in the services provided.

f. Continue our statewide coverage so that any service we can give is available to any child in the state.

g. Keep the programs now in operation functioning at the high level of service they have attained. Plans to expand the services seem to be unrealistic at this time because of staff and financial limitations.

4. Confidentiality

On September 15, 1950, the Montana State Board of Health adopted the following Administrative Code Rule, Regulation No.(16-2.16(1)-5610), which is still in effect:

"It shall be the policy of the Montana State Board of Health that all records and information concerning individuals, received in the office of the Department of Health, will be considered confidential and shall not be divulged by its employees to anyone without the consent of the individual concerned, except as may be necessary to provide necessary care for the individual or in the protection of the community, and then only shall be divulged to professional persons or public officials who are specifically concerned with the situation. Otherwise, information available to the State Department of Health shall be released only in reports of a statistical or tabular nature."

5. Eligibility - Civil Rights

Title V of the Civil Rights Act of 1964 states:

"No person in the United States shall on the grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."

Any application or recipient who feels he is discriminated against in any manner in the handling of his medical treatment may file a complaint under the Civil Rights Act of 1964.

6. General Information

Patients considered for care under Child Health Services must physically reside in Montana, be under 21 years of age, have a physical handicap, some potential for education and rehabilitation, and family who is unable to pay the cost of specialty care.

All children are eligible for a diagnostic evaluation only, regardless of family income.

7. Referral Sources

When it is suspected that a child has a physical handicap who may be eligible for Child Health Services, referrals may be made by:

a. The family doctor.

b. The Child Health Services approved doctor.

c. The local health department, public health nurse, and school nurses.

d. The local welfare departments.

e. Hospitals, clinics, or other health related agencies.

f. Family members.

8. Provision of Services

Because of the complexity of the medical and related problems in the patients referred, Child Health Services always has been and continues to be a specialty program--only those physicians, dentists, and paramedical personnel who possess board certification or are eligible for certification in their speciality may apply to Child Health Services and be approved to provide services rendered to eligible children under this program. In rare and extentuating circumstances may exist in which the MCH Bureau Chief may utilize other than board certified or eligible for certification personnel.

Conditions which may be covered in full or in part are listed below. For complete description of the conditions covered in full, part or not at all, please refer to the detailed guidelines and discussion of eligible diagnosis pages.

a. Orthopedic conditions that are potentially disabling.

b. Cardiac conditions requiring surgery.

c. Maxillofacial anomalies that can cause functional impairment.

d. Hearing disorders.

8. Provision of Services (Con't)

e. Urological conditions (to be qualified).

f. Neuromuscular conditions (to be qualified).

g. Certain defects requiring plastic surgery.

h. Certain other congenital handicaps (to be qualified).

i. Diagnosis only of new growths.

Child Health Services is not intended to treat all children with all types of handicaps. Budget restrictions are such that the bureau chief is charged with establishing priorities and determining which children may be accepted for treatment.

Hospitals must be licensed and approved by the State Department of Health and Environmental Sciences and by Child Health Services.

9. Pre-authorization of Services

All services provided by Child Health Services must be pre-arranged and pre-authorized by the Bureau Chief or his designated representative. Emergency authorizations may be given verbally by Child Health Services. Record of such verbal authorization must be noted in the patient's record and followed promptly with written authorization.

Acceptance of an authorization carries with it an agreement that no charge will be made to or payment accepted from a patient or his family unless the amount is determined and authorized by Child Health Services.

No payment shall be made by Child Health Services for unauthorized services or for any service rendered prior to acceptance for care.

Pre-authorization of participation is necessary in order to avoid misunderstanding and to insure that Child Health Services has funding enough to assist with that care.

Eligibility may begin from the date the referral is received by Child Health Services. Referrals may be received by letter, telegram or telephone.

9. Pre-authorization of Services (Con't)

Appliances may be purchased by Child Health Services on the recommendations of the approved clinician in charge of the patient's treatment plan when:

a. The case has been accepted for medical care on the basis of diagnostic and financial eligibility requirements.

b. There is no community resource to take care of this type of appliance.

Examples of appliances and supplies that may be purchased by Child Services are orthopedic braces, prostheses, hearing aids, walkers, orthodontic appliances, speech appliances, and protective helmets.

Examples of appliances and supplies not covered under Child Health Services are purchase of shoes, glasses, contact lenses, prothetic ears, artificial eyes, special beds, catheters, urinal bags, drugs, and immunizations.

Braces and prostheses may be purchased only from approved orthotists and prosthetists. Usually appliances made out of state are not authorized unless no comparable service is obtainable in the state.

10. Care Provided Out of State

Authorization of services out of state is permissible providing the patient has been referred by a Child Health Services board physician and equal services are not available within the state. The out-of-state referral must be approved by Child Health Services before funds can be committed to assist with this care. The out-of-state physician and facility must fulfill Montana Child Health Services requirements and be approved by this program.

The out-of-state physician must be willing to accept the Montana relative fee schedule which is used by Child Health Services.

11. Convalescent Home Care

Such care is authorized by Child Health Services only when such placement is medically indicated, not to exceed 30 days. Foster home care is not provided.

12. Exclusions

Transportation, room and board for needy families traveling long distances for services are not covered under Child Health Services, but every effort is made to help families find funding from other sources.

Doctor's visits for routine pediatric care.

Routine dental care, except those registered on the cleft palate program.

Follow-up office visits.

13. Termination of Care under Child Health Services.

Child Health Services involvement ends when:

a. The patient reaches his 21st birthday.

b. The physician or clinician following the patient feels there is no more need for further treatment (maximally corrected).

c. The family has left the state.

d. The family is not interested in continuing treatment or is in a financial position to assume full cost.

14. Referral

The referral to Child Health Services should be made in written form. In many instances the referral will be made orally. When this happens, notation must be made by the Child Health Services staff receiving the referral on the phone conversation form, DCC 12. A follow-up written referral will be requested. As stated earlier, the initial referral may be made by anyone, usually a written report from the child's physician is requested but is not required for registration. However, a written report is requested from the board approved physician before the child is eligible for financial participation.

15. Registration

Registration is completed when the parents or legal guardian has signed and dated the application form,

15. Registration (Con't)

DCC 5 and 6. Registration on Child Health Services is not to be interpreted as eligible for financial participation.

16. Un-met Needs

If a patient is found to be ineligible for services under Child Health Services or if a service performed for a Child Health Services patient is not approved for funding under the scope of the program, an "un-met need card" will be filled out and filed for future reference. The purpose of the un-met needs file is for registration and documentation of un-met but needed health services for handicapped children. This documentation will be very useful for future program planning, expansion, and gaining additional funding.

17. Care Plan

Diagnosis acceptable for care are contained in "Guidelines" and diagnostic section of this plan. Cases in approved categories are referred to the appropriate clinic or physician by appropriate Child Health Services staff.

Initial diagnostic evaluation other than in a Child Health Services clinic or physician's office will need to be approved by the bureau chief or the administrative assistant or case review committee.

18. Record Changes or Patients Placed for Adoption

When a child currently registered on Child Health Services is placed for adoption, a new record is made with the adoptive name. The medical information from the previous record is summarized or copied with the adoptive name. The old record is sealed and filed.

19. Closure of Records

When a child registered on Child Health Services is no longer to be followed by the program, the following procedures are taken:

a. Letter of discontinuance of service is sent to the family of the child for whom service is discontinued, explaining the reason for the

19. Closure of Records (Con't)

discontinuance. Copies of the letter go to the Child Health Services board physician that sees the patient, the child's physician, and the local public health nurse.

b. The clerk will place on the tickler file the action taken and why.

c. The chart will be stamped and placed in the inactive files until the child is 21 or the child dies.

d. At age 21 or the death of the child, the record will be placed in the closed files for ten years and then it will be destroyed.

20. Authorizations

All services to be paid for out of Child Health Services funds must be pre-authorized. This includes diagnostic evaluations, x-rays, surgery, hospitalization, anesthesia, lab work, physical and occupational therapy, speech correction, braces, hearing aids, orthodontia, dentistry and repairs.

There are no exceptions to this pre-authorization policy.

21. Cancellation of Authorization

When information comes to Child Health Services indicating that an authorized service was not given or that insurance has paid the expense in full, the authorization clerk will make the necessary entries on Child Health Services records, notify the agencies to whom the authorization was issued (if necessary) and notify the State Department of Health and Environmental Sciences fiscal office.

22. The Issuance of Authorizations.

a. Diagnostic evaluations - When a diagnostic evaluation is authorized, a copy of the authorization letter is sent to the family, public health nurse, and the Child Health Services approved physician to whom the patient is referred. The appointments then are arranged by the parents. Payment is made upon receipt of the report and statement.

22. The Issuance of Authorizations (Con't)

b. Hospitalization and surgery - The authorization letters are sent to the parents or legal guardian with copies sent to the public health nurse, child's local physician, the board approved physician or hospital.

The authorization form is also filled out noting the MMA Relative Schedule Code for the requested surgery and the cost. The authorizations are to be signed by the bureau chief or his administrative assistant.

The anesthesiologist may not be known at the time authorization is given, but can be completed when the bill is received. The completed authorization will be sent to the proper physician. The hospital will be authorized for a specified number of days. If the hospital stay needs to be extended beyond the authorized amount, a request from the admitting physician is necessary.

Payment will be processed upon the receipt of completed authorization and operative report from the hospital.

The physician fees are in agreement with the Montana Medical Association Relative Value Scale (RVS) and approved by the Director of the Department of Health and Environmental Sciences. Currently, the April 1972 fee schedule rate is used, and the authorization form completed with the exception of the physician anesthesiologist's name.

When the skills of two surgeons are needed, they will be paid according to the guidelines of the RVS.

Anesthesiologists will be reimbursed according to the RVS.

Participating specialists agree not to charge families for difference between their customary fees and the Child Health Services approved RVS.

If the surgeon performs multiple procedures, the major surgery is covered in full as stated above and the other surgeries at one half the RVS.

If the procedure is on the basis of individual consideration, final decision as to amount of payment will rest with the bureau chief or his assistant and the participating physician.

22. The Issuance of Authorizations (Con't)

c. Occupational and physical therapy - The philosophy in providing services for occupational therapy or physical therapy is to help with the complete correction of surgical treatment. Usually, physical therapy and occupational therapy will be authorized for a period of three months at two times per week (or 24 sessions). It is expected the parents will be taught to continue the various therapies at home. In some cases, the authorization for occupational therapy or physical therapy may need to be extended. This may be done when requested by the board approved orthopedist. These services must be approved by the review committee. The committee may also request the addition of an occupational therapist or a physical therapist for the review of such requests. Payment will be made upon receipt of completed authorizations and reports.

d. Speech correction - Speech correction has not been a service that is provided through Child Health Services. There are rare cases in which a limited amount of speech correction will benefit the child. If no other resources can be utilized, then Child Health Services may provide speech correction not to exceed two sessions per week for no more than three months.

Speech correction need not be recommended by a physician but a Child Health Services board approved speech pathologist. The request will be reviewed by the Child Health Services speech pathologist and by the review committee. Payment will be made upon receipt of completed authorizations and reports.

e. Authorization for appliances - All appliances, with the exception of hearing aids, must be ordered by a board approved physician. Usually, the physician's request will come directly to Child Health Services, who in turn will make arrangements with the appliance vendor. Repairs to such appliances must be pre-authorized. Repairs under $50 will be the responsibility of the patient, unless circumstances arise, then the review board may determine Child Health Services participation. Hearing aids must be recommended by a board approved audiologist and purchased from a participating and approved hearing aid dealer. Repairs of hearing aids will be treated the same as repairs of other appliances. Aids no longer needed should be returned to Child Health Services offices.

22. The Issuance of Authorizations (Con't)

f. Authorization for dentistry, orthodontia, and dental prosthesis - General dentistry will be approved for eligible children according to the Dental Relative Value Scale as approved by the director of the Department of Health and Environmental Sciences. The board approved dentist will request the authorization by giving the code numbers for the recommended treatment. The general dentistry provided is very minimal and only for those children born with cleft lip and/or palate. Parents are expected to keep the children's teeth in good repair, but in those cases where history shows dental neglect and the child is eligible, then dentistry may be authorized.

Orthodontia must be approved by the cleft palate team and pre-authorized in accordance with the agreement established between the board approved orthodontists and the Department of Health and Environmental Sciences. There are some rare cases which are not cleft lip and/or palate related requiring orthodontia; i.e., Treacher Collins Syndrome. In these cases, orthodontia may be approved by the review committee.

Dental prosthesis may be authorized when recommended by a cleft palate team and done by a board approved dentist. The payment will be pre-authorized according to the approved RVS.

g. Insurance coverage and children receiving Title XIX benefits - All of Child Health Services participation is subject to insurance benefits. All vendors are expected to receive all insurance benefits possible before billing the balance to Child Health Services. If insurance pays more than what the approved RVS allocates for that service, then the total insurance will be determined as total payment for the services and Child Health Services will not participate.

If a vendor refuses to file a claim, then the parents are instructed to file a claim for expenses. Child Health Services may supply the necessary information and send the insurance form to the parents to complete. The parents then reimburse Child Health Services when they receive payment from insurance. Copies of referral letters are required before Child Health Services will release the authorized funds for the services rendered.

22. The Issuance of Authorizations (Con't)

Children who are eligible for medicaid benefits will receive services utilizing their Medicaid services. In cases where hospitalization will be longer than 15 days, then Child Health Services may participate in the hospital services in order to save hospital days in case of emergency. All other fees will be billed to Medicaid services by the vendor.

23. Case Review Committee

The case review committee is formed to assist with the discussion of and determining Child Health Services participation in certain defined conditions and services. The committee will consist of the MCH Bureau Chief, the administrative assistant, Child Health Services social services consultant, an MCH nursing consultant, a practicing pediatrician, and one secretary. This committee will meet a minimum of two times per month and will review cases which:

a. Are listed in the areas of treatment that may be provided if approved by the review committee.

b. Extending of occupational therapy, physical therapy, and speech correction.

c. Problem cases and cases regarding the lack of pre-authorization.

d. Assist in the development of necessary program changes.

e. Initial hospitalization extensions.

f. Approve applications of vendors seeking board approval.

g. Discussion any situations not clearly covered by existing policies and procedures.

24. Child Health Services Relations with Other Agencies

a. Federal

Public Health Services, Health Services and Mental Health Administration and Maternal and Child Health for both matching funds and consultation through the Regional Office in Denver.

24. Child Health Services Relations with Other Agencies (Con't)

Regional Heart Program in Minnesota which provides funds for about 25 Montana children each year.

b. State

Department of Social and Rehabilitative Services
Vocational Rehabilitation - Most children, when they reach the age of 16 are referred to this program.

Economic Assistance for Title XIX benefits.

Department of Public Instruction

Department of Institutions

c. Local

County Social and Rehabilitative Services offices

City-County health offices

Local schools

Service organizations

d. Service organizations

National Foundation (March of Dimes)

Shriner's Hospital

Easter Seal Society of Montana

Cystic Fibrosis Foundation

Other national and local service agencies

25. Guidelines for the Determination of Eligibility for Financial Participation

a. Introduction

Financial status of the families involved becomes an important factor because private costs of services for these congenital handicapping conditions in many instances is beyond the financial capabilities

25. Guidelines for the Determination of Eligibility for Financial Participation (Con't)

of the average family. However, many families are able to contribute to the partial cost of care, though not able to manage total cost of care on a private basis.

Financial participation offers the parent a chance of most direct participation in meeting the care of his child and theirs, but he assumes his rightful responsibility as a parent. This allows a broader utilization of funds so more children can benefit from Child Health Services. The funds are drawn from their own financial resources, health and/or medical insurance, other agencies and organizations, and Child Health Services.

b. Objective

To provide the necessary medical and dental care when needed, to correct certain congenital handicaps and to prevent further handicapping.

To help families with children who have certain handicapping conditions utilize available medical and dental resources.

c. Definitions

Dependent - A person, including one's self, spouse, children and certain other relatives, to whom one contributes all or a major amount of necessary financial support.

Residence - A child's residency is determined by his parents or legal guardians who must reside within the Montana state boundaries. Care can be provided if the state of residence agrees to reimburse Montana for care.

Annual Income - Family income and resources should be computed on an annual basis. It is essential that the economic level of families applying for Child Health Services is known.

Gross Income - Gross income consists of income from self employment and/or salaries or wages before deductions. The income of self-employed persons and owners of businesses should be considered on an individual basis (see individual federal or state income tax return).

25. Guidelines for the Determination of Eligibility for Financial Participation (Con't)

Family - The total number of dependents.

Farm or Ranch Income - Gross amounts of sales plus amount of produced and consumed materials and food less taxes and assessments, interest paid on mortgage, and repair and minor replacement of equipment, fertilizer, seed, spraying, fuel, etc, rental of equipment and wages. Depreciation of equipment is not deductible. Principle payments on mortgages are not deducted.

Vendor - Child Health Services approved specialists, hospitals, labs and appliance shops.

d. Guidelines

Diagnosis - The original diagnosis is without charge but must be pre-authorized by the bureau chief or the administrative assistant. A written report from the board physician, dentist or paramedical individual will be required before payment or consideration for financial participation can be determined. In the case of emergent need, a telephone report will be accepted.

Office Visits and Followup - The office call is the responsibility of the parents. X-rays may be participated with if pre-authorized by Child Health Services.

Repairs - Repairs of appliances are the responsibility of the parents. If the cost of repairs exceeds $50, then Child Health Services will be able to financially participate with the excess of $50.

Exceptions - The requirement for financial participation for treatment may be set aside and not required when the Maternal and Child Health Bureau Chief determines that the child will not receive proper treatment or that his health or condition will deteriorate to a harmful degree unless Child Health Services intervenes. These cases must be noted in the patient's record by the chief to reflect parental neglect or other circumstances making intervention necessary.

25. Guidelines for the Determination of Eligibility for Financial Participation (Con't)

Length of Eligibility - Eligibility is for one year only. If more than one prcoedure is done in a year, then a new request for financial participation must be prepared. A new social study will be requested each year to determine continued eligibility for financial participation.

Adoptions - Child Health Services will be available to the child who has been adopted as long as the child and the family are eligible for financial participation.

Children in State Institutions - Children in state institutions are eligible for Child Health Services if their parents meet the eligibility requirements and the condition is one that falls within the Child Health Services program.

Emancipated Minors - Financial eligibility for married children should be determined on the basis of the income of the husband-wife family unit, not on the basis of the income of the parents unless the parents are supporting the family unit. Financial eligibility for unmarried children over age 18 who are not under parental support should be based on the income of the child.

Payment Plan - All available hospital, medical-surgical and major medical insurance benefits carried and preminiums paid by the family will be applied toward the program costs. The amount of family financial participation as determined and explained to the family is the maximum amount the parent or guardian is asked to pay during the coming year or until the next determination, whichever comes first. It is understood that if the program costs for the year happens to be in a lesser amount than the determined family financial participation, then the parents will be asked to meet only the lesser amount.

Payment will be made in accordance with a plan worked out between the family and places and people providing the treatment. Child Health Services will authorize after the parents have made arrangements to pay for their suggested amount.

25. Guidelines for the Determination of Fligibility for Financial Participation (Con't)

Appeals - The applicants shall have the right to appeal should there be any dissatisfaction because of the Child Health Services staff function.

---Rejection of financial assistance.
---The determination of amount of financial participation by Child Health Services.
---Unreasonable delay by the Child Health Services staff in acting upon an application for services.
---Denying the opportunity to apply for services.

The appeals board is the Board of Health and Environmental Sciences. Appeals should be written to Dr. Arthur C. Knight, Director, Montana Department of Health and Environmental Sciences, Helena, Montana 59601.

e. Insurance - The family will be given credit if they have health insurance which covers the patient. The amount the family pays toward the premium will be included as part of the family's participation. For example, if a family pays $300 a year on their health insurance and the formula reveals a $300 participation by the family, then Child Health Services would assist subject to insurance benefits on any pre-authorized care. If the balance after insurance benefits is less than $20, the family will be responsible.

f. Determination of Eligiblity for Financial Participation - The bureau chief or administrative assistant will determine and approve financial participation. Financial participation is determined through the use of the application for Child Health Services and request for financial help (DCC5-DCC6), which is completed at least annually by the parents or legal guardians of the child. Eligibility determination is arrived at by calculating the family size number and family income number and subtracting the family size from the family income. If the result is zero, the child is eligible for all services to be paid by Child Health Services. If the result is greater than zero, the responsible persons (parents or guardians) will be required to pay a specific amount as a deductible within 12 months before Child Health Services can pay for treatment services. This deductible amount may vary and current rates shown in following tables are used.

Sample:

Family A has two parents and four children. One child has a congenital hip. Their gross income is $7,600 per year. Would they be eligible for total care?

There are six dependents in this family. Their income number is seven in order to derive family participation. Then, subtract family size (six) from family income number (7), which leaves a family participation number of one or $60 per year.

Family B has two parents, one grandparent dependent upon the household salary and two children and earns a gross income of $5,567 yearly. One child has a cleft lip and palate.

The family size number is five. The family income is four. Income participation is zero, so full participation would be available.

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Family size number equals the number of dependents including the patient.

Family income number:

Gross Income Per Year	Family Income Number	Gross Income Per Year	Family Income Number
0 - 3,699	0	11,500 - 12,099	14
3,700 - 4,299	1	12,100 - 12,699	15
4,300 - 4,899	2	12,700 - 13,299	16
4,900 - 5,499	3	13,300 - 13,899	17
5,500 - 6,099	4	13,900 - 14,499	18
6,100 - 6,699	5	14,500 - 15,099	19
6,700 - 7,299	6	15,100 - 15,699	20
7,300 - 7,899	7	15,700 - 16,299	21
7,900 - 8,499	8	16,300 - 16,899	22
8,500 - 9,099	9	16,900 - 17,499	23
9,100 - 9,699	10	17,500 - 18,099	24
9,700 - 10,299	11	18,100 - 18,699	25
10,300 - 10,899	12	18,700 - 19,299	26
10,900 - 11,499	13		

Family income minus family size equals family participation for 12-month period:

Family Participation Number	Yearly Amount Participation	Monthly Amount of Participation
0	$ 0.00	$ 0.00
1	60.00	5.00
2	150.00	12.50
3	300.00	25.00
4	500.00	41.67
5	750.00	62.50
6	1,000.00	83.33
7	1,250.00	104.12
8	1,500.00	125.00
9	1,750.00	146.83
10	2,000.00	166.67
11	2,250.00	187.50
12	2,500.00	208.33
13	2,750.00	229.17
14	3,000.00	250.00
15	3,250.00	271.00
16	3,500.00	293.66
17	3,750.00	312.50
18	4,000.00	333.33
19	4,250.00	354.17
20	4,500.00	375.00
21	4,750.00	395.83
22	3,000.00	416.67
23	5,250.00	437.50
24	5,500.00	458.33
25	5,750.00	479.17
26	6,000.00	500.00

SECTION III. B. THE CHILD HEALTH SERVICES PROGRAM - SCOPE AND CONTENT

26. Diagnosis and Treatment Eligible for Child Health Services Participation

a. Diagnosis and Treatment - To reiterate the philosophy and intent of Child Health Services is to assure the emotional, nutritional, health education, and rehabilitative services for those children under 21 who are eligible for the program services. Budget limitations have made it necessary to define which categories will be eligible. Therefore, the following categories will not be covered:

---Conditions for which the cost is high and rehabilitative and educational prognosis is low.

---Acute injuries and illness. These are generally short-term illnesses and are generally not physically handicapping.

---Cancerous conditions judged to be too costly for which rehabilitative results are low.

---Medical conditions such as diabetes, pneumonia, blood dyscrasias.

---Any conditions not listed will be reviewed by the case review committee.

b. Representative Conditions and Treatments Approvable Under Child Health Services

Defect	Treatment
Musculoskeletal System:	
Amputees	Revision of stump; prostheses and training.
Arthritis, rheumatoid	Prevention and treatment of contractures and deformities (medical care and drugs excluded). General orthopedic care and applicances (slings, etc.)
Bowing of tibia with or without pseudarthrosis	Surgical correction or amputation.

26. Diagnosis and Treatment Eligible for Child Health Services Participation (Con't)

Defect	Treatment
Chondrodystrophy (e.g., Ollier's Disease)	Surgical correction.
Clubbing of foot or hand	Manipulative or operative correction.
Congenital bands	Surgical correction.
Contractures	Manipulative or operative correction.
Dislocation of hip	Manipulative or operative correction - splints, casts, etc.
Dislocation of patella, elbow, shoulder-recurrent	Manipulative or operative correction.
Fractures of elbow	Manipulative or surgical treatment.
Genu recurvatum valgum	Closed or open reduction.
Muscular Dystrophy	Orthopedic appliances for purposes of strengthening weak musculature and support.
Nucleus pulposis, extruded; intervertabrae disc, crushed or ruptured	Surgical correction.
Osteitis deformans and osteochondritis dissecans	Surgical correction.
Osteogenesisimperfecta	Surgical correction of residual deformities, therapies, equipment.
Osteomyelitis (excluding TB of bone and joints)- acute	Surgical care when involving a joint.
Pes planus and cavus	Surgical correction.
Polydactyly and syndactyly	Surgical correction.

26. Diagnosis and Treatment Eligible for Child Health Services Participation (Con't)

Defect	Treatment
Poliomyelitis and transverse myelitis deformities	Rehabilitation, appliances (leg lengthening procedures are excluded).
Scoliosis	Conservative or operative care, appliances.
Tenosynovities, etc.	Surgical correction.
Torticollis	Surgical correction.
Neuromuscular:	
Cerebral Palsy (both congenital and result of cerebro-vascular accident)	Diagnostic evaluation; rehabilitative surgery, physical and occupational therapy, occasionally speech theraphy, braces and other appliances as needed; diagnostic evaluation.
Craniosynostoses	Surgical correction.
Spinal cord injuries	Orthopedic bracing only.
Gastrointestinal:	
Trachial esophageal fistula	Surgical care.
Intestinal Stenosis	Surgical care.
Imperferated anus	Surgical care.
Phloric Stenosis	Surgical care.
Cardiovascular System:	
Referred cases with congenital heart disease felt to have good prognosis for life following surgery	Diagnostic and followup done through Heart Diagnostic Center in Great Falls; patients for surgery must be referred by Heart Center to one of the following: Mayo Clinic, University of Minnesota or University of Washington.

26. Diagnosis and Treatment Eligible for Child Health Services Participation (Con't)

Defect	Treatment
Pacemaker implantation and replacement	Child Health Services will cover the cost of pacemaker implantation and replacement (required about every two years). This will be included in the program since it is a surgical condition.
Integumentary System (Skin)	
Burns (only after initial care and epidermilysis	Plastic surgery-skin grafts, excision of scar tissue and reconstruction, orthopedics-relief of contractures, rehabilitation.
Genitourinary System	
Epipaspadius	Surgical correction.
Hypospadius	Surgical correction.
Extrophy of bladder	Surgical correction.
Ear	
External auditory canal, congenital or acquired deformity	Fitting with hearing aid.
Hearing disabilities	Diagnostic evaluation, hearing aids, auditory training speech and language therapy and speech reading, ossicular chain reconstruction, and tympanoplasty, insertion of myringotomy tubes in those patients who have a long history of chronic ear disease only after conservative measures have failed. T & A may be provided in rare and extenuating circumstances and when justified to Child Health Services satisfaction.
Mastoiditis (Chronic)	Surgery, hearing rehabilitation.

26. Diagnosis and Treatment for Child Health Services Participation (Con't)

Defect	Treatment
Miscellaneous	
Chest, congenital malformations of (groove, funnel, pigeon)	Surgery if interference with respiration.
Cleft lip and palate	Plastic surgical correction; obturators; speech therapy; orthodontics (department of orthodontics covers dental surgery - Child Health Services involved in hospitalization and anesthetist fee for same); dental care may be provided when it is felt that the patient will not otherwise obtain dental care.
Diaphragmatic hernia	Surgical correction.
Lowphenylalanine	Formula.

c. Representative Conditions Eligible for Individual Consideration at Case Review Committee

Defect	Treatment
Bone tumors and cysts	Surgical correction.
Spina bifida	Surgical correction.
Amyotonia	Surgical correction.
Subdural hemotomia	Surgical correction.
Hemangionoma	Surgical correction.
Respiratory system defects	Reconstructive surgery.
Tonsil and adenoidectomy	In rare and extenuating circumstances and when justified to Child Health Services satisfaction.
Bronchiectasis	Surgery.

26. Diagnosis and Treatment for Child Health Services Participation (Con't)

Defect	Treatment
Occupational therapy, physical therapy	Manipulation.
Speech correction	Language, etc.
Cryptorchidism	Surgery.
Hydrocele	Surgery.
Congenital anomalies and defects of kidneys and ureters	Surgery.
Congenital Bands and adhesions	Surgery.
Megacolon e.g. Hirsch-sprung's Disease	Surgery.
Malignancies and tumors	Surgery.
Esophageal atresia	Surgery.
Malrotation of gut	Surgery.

d. Representative Conditions and Treatments Not Approvable for Funding under Child Health Services

Genito-Urinary System:

---Hermaphrodism or pseudohermaphrodism
---Any renal disease - acute or chronic
---Kidney transplants

Ear:

---Microtia not covered for surgical construction of prosthetic ear
---Bilateral abnormality or atresia of ear canals not covered for attempts at reconstruction of canals nor unilateral abnormality if hearing is normal on the good side.

26. Diagnosis and Treatment for Child Health Services Participation (Con't)

d. Representative Conditions and Treatments Not Approvable for Funding under Child Health Services (Con't)

Eyes:

---All problems with eyes are referred to the Visual Services Division, Department of Social and Rehabilitative Services.

Miscellaneous:

---Treatment for anemia of any type
---Bilirubinemia from any cause
---Hernias - femoral, inguinal, omphalocele, umbilical, ventral
---Blood dyscrasias
---Diabetes mellitis
---Most malignancies and tumors
---Treatment for behavior disorders, emotional problems and learning disorders when unrelated to neurologic impairment or other Child Health Services eligible condition
---Manipulative techniques and cortisone injections for bursitis
---Endocrine diseases - all types
---Except through Child Health Services diagnostic clinics, medical management and education for children with only mental retardation
---General medical management of microcephaly and macrocephaly
---Management of tuberculosis not involving bone and joints
---Malnutrition and vitamin deficiencies
---Medical management of poisonings
---Office visits

Musculoskeletal System:

---Treatment of actue uncomplicated fractures (except elbow)
---Shoes for pes planus, tibial torsion

Neuromuscular System:

---All neuromuscular problems except those listed as eligible or to be reviewed

26. Diagnosis and Treatment for Child Health Services Participation (Con't)

d. Representative Conditions and Treatments Not Approvable for Funding under Child Health Services (Con't)

Integument:

---Acute care for burns

Cardiovascular System:

---Any defect held to be nonsurgical or for which there is no acceptable good palliative or correctable procedure

Respiratory System:

---Asthma and allergic disorders
---Cystic Fibrosis
---Emphysema
---Respiratory distress syndrome of newborn

Gastrointestinal System:

---Biliary atresia
---Portal hypertension
---Colitis
---Celiac Disease

SECTION IV. DEMONSTRATION AND SPECIAL PROJECTS

SECTION IV. DEMONSTRATION AND SPECIAL PROJECTS

A. LANGUAGE, SPEECH AND HEARING PREVENTION AND CORRECTION PLAN

1. Conditions for State Participation

a. Definition of Terms

---Language is any means of expressing or communicating thoughts or feelings.

---Speech is the process by which oral symbols are produced. This process involves the auditory pathways and the intricate coordination among several neuromuscular mechanisms including the respiratory, phonatory, resonatory and articulatory systems.

---Hearing is a disorder of language and speech as related to loss of hearing acuity. This is not to be misconstrued with the assessment of hearing losses and the fitting of hearing aids. The speech pathologist deals with the language and speech problems that are secondary to hearing disorders.

b. Legal Basis

The state laws that are applicable to the State Department of Health and Environmental Sciences, Crippled Children's Services and Maternal and Child Health are also applicable to the language, speech and hearing program.

c. Administration Process

Director of the Montana Department of Health and Environmental Sciences

Health Services Division Administrator

Maternal and Child Health Bureau Chief

Coordinator of the language, speech and hearing program.

d. Employment

Employees of the State Department of Health and Environmental Sciences are covered by a merit system of personnel administration established in compliance with the Federal Social Security Act and state law to assure fair treatment of all employees in all personnel actions.

SECTION IV. DEMONSTRATION AND SPECIAL PROJECTS (Con't)

A. LANGUAGE, SPEECH AND HEARING PREVENTION AND CORRECTION PLAN (Con't)

1. Conditions for State Participation (Con't)

d. Employment (Con't)

Supportive personnel workers have not been employed extensively in Montana. None have been employed specifically for language, speech and hearing correction. Nonpaid volunteers have been used as recorders in the screening of speech disorders.

e. Public Information

The program's efforts to acquaint interested persons, organizations, and the general public with speech and hearing correction services will be as follows:

---Committees (e.g., Comprehensive Health District-Wide Planning Committees to assist with district planning).

---Talks at civic groups such as the PTA, Lions, etc.

---News media. News releases to newspapers, radio and television.

---Public information. Frequently special articles are prepared for specific papers, television or radio stations when the activity involves the area these news media serve.

---Reports. The language, speech and hearing correction program is included in the annual reports to the governor. A yearly report will be submitted to the granting agency.

f. Purchase of Service

Out-patient diagnostic services for language, speech and hearing problems are available without restriction as to race, national origin, color, creed, sex or financial status. The speech services are available through the mobile clinics, and hearing evaluations are available through the hearing conservation program located in Helena and Billings. These evaluations are without cost to anyone under 21 years of age. All referrals for speech and language disorders will be evaluated by one of the mobile clinics.

SECTION IV. DEMONSTRATION AND SPECIAL PROJECTS (Con't)

A. LANGUAGE, SPEECH AND HEARING PREVENTION AND CORRECTION PLAN (Con't)

1. Conditions for State Participation (Con't)

g. Payment for Correction

Correction of speech problems will be without charge to any child under the age of 21 when the correction is provided by the State Department of Health and Environmental Sciences. Payment cannot be made to other agencies by the State Department of Health and Environmental Sciences for speech correction, even if the referral is made by the State Department of Health and Environmental Sciences.

h. Standards Governing Care

Speech Pathologist III - Under administrative direction, he performs responsible professional work in the field of speech pathology and plans and directs the statewide program in speech correction. He may coordinate the cleft palate teams of the Crippled Children's Service.

Examples of work performed: Plans and directs statewide programs for correction of speech and language disorders in conjunction with medical specialists, educators, public health nurses, officials of other state agencies, voluntary health organizations and professional groups. Coordinates the activities of particpating agencies in the program. Consults with physicians, nurses, educators, and public health nurses concerning speech and language problems. Directs the organization of local teams consisting of parents, educators, physicians, public health nurses and speech pathologists to find, evaluate and treat children with speech and language disorders. Acts in an advisory capacity to local areas concerning standards of corrective procedures and adequacy of facilities for therapy. Works out problems which arise from lack of adequate facilities for treatment. Directs and coordinates staff speech pathologists in their assigned duties. May participate as a clinician on one or more cleft palate teams or may function as coordinator of the cleft palate program. As coordinator of the cleft palate program, the duties are:

---Plan a statewide program for habilitation of cleft lip and cleft palate children.

---Coordinates the cleft palate program and all cleft palate teams including:

SECTION IV. DEMONSTRATION AND SPECIAL PROJECTS (Con't)

A. LANGUAGE, SPEECH AND HEARING PREVENTION AND CORRECTION PLAN (Con't)

1. Conditions for State Particpation (Con't)

h. Standards Governing Care (Con't)

Acts as liaison among the team members and between teams and state staff.

Brings together the individual team members' reports on the evaluation of a child who has been examined and their final team decision as to the course of treatment in order to advise the family physician and dentist of the evlauation and the planned course of treatment.

Corresponds with family physicians and dentists who refer a child to one of the teams.

With the advice and cooperation of the bureaus of Dental Health, Nursing and Health Education and team members, he helps to plan meetings to explain the cleft lip and palate program to lay and professional groups.

Helps with planning of the program with regard to improvement of service and addition of needed equipment.

Participates in educational activities such as orientation courses, in-service training and staff development programs and in the preparation of educational materials and bibliographies on the subject of speech and cleft palate case findings, treatment, and rehabilitation in cooperation with other professional personnel.

Prepares reports, technical papers and expository articles. Performs related work as required.

Minimum qualifications:

---A master's degree in speech pathology from an accredited college or university and five years of progressively responsible and successful experience in speech correction, one of which must have been in a responsible position in a cleft palate program as either a clinical or coordinating member of a cleft palate team consisting of surgeons, dentists, pediatricians, speech clinicians, and other professional workers, and one of which must have involved responsible work

h. Standards Governing Care (Con't)

with community and professional groups and organizations in speech correction programs.

Additional education in speech pathology and audiology beyond the master's degree at an accredited college or university may be substituted on a year-for-year basis for the general experience to a maximum of two years. No substitution may be made for the year of experience in a cleft palate program or in working with community or professional groups in a speech correction program.

---Clinical certification in speech pathology from the American Speech and Hearing Association.

---Thorough knowledge of the theory, technique and practice of speech correction and of cleft palate habilitation, of the functions of health, welfare and allied agencies, and of the relationships involved in working with them, of sources of information and facilities for speech correction services. Thorough knowledge and understanding of educational methods related to the specific problems of children with defective hearing, speech or cleft palate. Considerable knowledge of current literature in the field of speech correction, of the team method of cleft palate habilitation, and of the principles of supervision. Knowledge of the principles and methods of public health administration.

---Ability to provide leadership to groups composed of representatives from several agencies, professional disciplines and the general public, to work with individuals and groups in order to effectively organize work, to establish objectives and to adapt procedures and methods to meet these objectives, to recognize problems.

---Must possess the personal attributes necessary for the performance of the assigned work and be suitable for employment as evidenced by an investigation. Must have the physical ability to do the work without hazard to self or others.

SECTION IV. DEMONSTRATION AND SPECIAL PROJECTS (Con't)

A. LANGUAGE, SPEECH AND HEARING PREVENTION AND CORRECTION PLAN (Con't)

1. Conditions for State Participation (Con't)

h. Standards Governing Care (Con't)

Speech Pathologist II - Under administrative direction, he performs responsible professional work in the field of speech pathology and may assist in the direction and coordination of a statewide program.

Example of work performed: Assists in planning a statewide speech and language program in conjunction with medical specialists, educators, public health nurses, officials of other state agencies, voluntary health organizations, and professional groups. Assists in coordinating the activities of particpating agencies in the program. Consults with physicians, nurses, teachers, and public health workers concerning speech screening methods and procedures. Organizes local teams consisting of parents, teachers, physicians, public health nurses and speech clinicians to find, evaluate and treat children with speech and language disorders. Advises local teams of therapy procedures and facilities available for treatment. Participates as a clinician on one or more cleft palate teams or may function as coordinator of such teams in the State Department of Health and Environmental Sciences cleft palate program. Directs or supervises speech pathologists of a lower classification. When necessary, supervises testing, interprets results, recommends treatment and makes arrangements for treatment. May evaluate and determine the clinical status of and render treatment to persons with communicative disorders. Participates in educational activities such as orientation courses, in-service training and staff development programs and the preparation of education materials and bibliographies on the subject of speech and hearing case findings, treatment and rehabilitation in cooperation with other professional personnel. Compiles statistics, makes studies and prepares reports, technical papers and expository articles. Performs related work as required.

Minimum Qualifications:

---A master's degree in speech pathology from an accredited college or university and four years of progressively responsible and successful employment experience in speech correction.

A. LANGUAGE, SPEECH AND HEARING PREVENTION AND CORRECTION PLAN (Con't)

1. Conditions for State Participation (Con't)

h. Standards Governing Care (Con't)

Additional education in speech pathology beyond the master's degree at an accredited college or university may be substituted on a year-for-year basis for the required experience to a maximum of two years.

---Certificate of Clinical Competence in speech pathology from the American Speech and Hearing Association.

---Thorough knowledge of the theory, technique, and practice of speech correction, and thorough knowledge and understanding of educational methods related to the specific problems of children with speech and language disorders. Considerable knowledge of current literature in the field of speech correction and hearing conservation and of the sources of information regarding facilities for speech correction services. Some knowledge of public health administration.

---Ability to provide leadership to groups composed of representatives from several agencies, professional disciplines and the general public, to work with individuals and with groups in order to effectively instruct and counsel, to plan and effectively organize work, to see objectives clearly and adapt procedures and methods to meet them, to recognize problems and take initiative in solving them, to evaluate patient progress, to supervise subordinate employees, and to express ideas and instructions clearly and concisely, orally and in writing. Must possess the personal attributes necessary for the performance of the assigned work and be suitable for employment as evidenced by an investigation. Must have the physical ability to do the work without hazard to self or others.

Speech Pathologist I - Under general supervision, he performs responsible work in the evaluation, diagnosis and therapy of persons having communicative disorders.

Examples of work performed: Evaluates patients for speech and language disorders and administers correction to patients, including the hard of hearing. Helps patients make the best possible use of his communicative potential so that he may become as independent and integrated a personality as possible.

h. Standards Governing Care (Con't)

May participate as a speech pathologist on one or more cleft palate teams. Works with lay and professional groups in order that they may understand better the problems and needs of those having speech disorders. Participates in in-service training programs for the professional staff of the State Department of Health and Environmental Sciences and for teachers. May supervise speech technicians of a lower classification. Keeps clinic records and makes studies and reports as required. Performs related work as required.

Minimum Qualifications:

---A master's degree in speech pathology from an accredited college or university, eligibility for clinical certification in speech pathology by the American Speech and Hearing Association; or, a bachelor's degree from an accredited college or university with a major in speech pathology, clinical certification in speech pathology from the American Speech and Hearing Association.

---Thorough knowledge of the theory, technique and practice of speech correction. Considerable knowledge of the relationships involved in working with public health and allied agencies. Considerable knowledge and understanding of general educational methods related to the specific educational problems in organic and functional disorders of children. Some knowledge of current literature in the field of speech and language pathology and hearing conservation, and of the various sources of information regarding communicative disorders and facilities for speech correction services.

---Ability to establish and maintain cordial working relationships with others, to carefully and sympathetically instruct and guide patients and parents in assuming their responsibility in a program of development, to evaluate patient progress, to see objectives clearly and to adapt procedures and methods to meet them, to effectively organize work, and to express ideas and instructions clearly and concisely. Must possess the personal attributes necessary for the performance of

the assigned work and be suitable for employment as evidenced by an investigation. Must have the physical ability to do the work without hazard to self or others.

Speech and Hearing Clinician - Under supervision, he renders speech and hearing therapy services and performs related work as assigned.

Examples of work performed: Tests patients for speech and hearing disorders and detects and gives direct speech and hearing therapy to patients, including speech reading. Helps the patient make the best possible use of his speech and hearing potentials so that he may become as independent and integrated a personality as possible.

Minimum Qualifications:

---A bachelor's degree in speech pathology and audiology from an accredited college or university.

---Considerable knowledge of the theory, technique and practice of speech and hearing therapy. Some knowledge of the relationships involved in working with public health and allied agencies, of current literature in the field of speech correction and hearing conservation, and of the various sources of information and facilities regarding speech and hearing therapy services. Some knowledge and understanding of general educational methods related to the specific educational problems in organic and functional speech and hearing disorders of children.

---Ability to establish and maintain cordial and constructive working relationships with others, to carefully and sympathetically instruct and guide patients and parents in assuming their responsibility in a program of development, to see objectives and work toward their attainment, to effectively organize work, and to express ideas and instructions clearly and concisely. Must possess the personal attributes necessary for the performance of the assigned work and be suitable for employment as evidenced by an investigation. Must have the physical ability to do the work without hazard to self or others.

SECTION IV. DEMONSTRATION AND SPECIAL PROJECTS (Con't)

A. LANGUAGE, SPEECH AND HEARING PREVENTION AND CORRECTION PLAN (Con't)

1. Conditions for State Participation (Con't)

i. Procedures Followed in the Authorization of Services

Diagnostic services under the State Department of Health and Environmental Sciences Maternal and Child Health Bureau are made available to any child without charge, restriction, or requirement as to the economic status of the child's family without regard to race, religion, sex or creed. The initial referral may come from any source. Regardless of the referral source, as much medical, social, educational and psychological background information as possible on the child is obtained prior to the diagnostic evaluation.

Speech correction services will be available through the speech program. These services are without charge to the family. Where another federal, state or local agency is able to pay the State Department of Health and Environmental Sciences for children under their jurisdiction, a bill will be sent to them for speech services. The only restriction to speech correction will be the speech pathologist's case load and the availability of speech and language services in the district in which the child lives.

2. Health Services Division - Maternal and Child Health Bureau

a. Goal

To assist in the reduction of language, speech and hearing problems of children under 21 years of age.

b. Needs and Problems

The prevalence of speech disorders among children between the ages of 5 and 21 has been traditionally accepted as five percent of that total population (ASHA Committee on the Midcenture Whitehouse Conference, JSHD 17:129-137 - 1952). A more recent study shows that 31.6 percent of the population in grades 1 through 12 were moderately deviate in articulation and 2.0 percent were extremely deviate in articulation (ASHA 1971). The highest incidences of articulation disorders are in the first five grades. Both of these groups are in need of speech correction for articulation disorders. Valid statistics describing language and speech disorders among pre-school children are not published. Language and speech disorders appear to be prevalent among pre-school children. Several

SECTION IV. DEMONSTRATION AND SPECIAL PROJECTS (Con't)

A. LANGUAGE, SPEECH AND HEARING PREVENTION AND CORRECTION PLAN (Con't)

2. Health Services Division - Maternal and Child Health Bureau (Con't)

b. Needs and Problems (Con't)

surveys done by the State Department of Health and Environmental Sciences reveal that about 12 to 15 percent of all Montana pre-school children age 2 1/2 to 6 years of age do have a language and/or speech disorder. The language or speech disorder could be handicapping enough to cause the child adjustment problems during the first several grades of school. Although the determination of the severity of a hearing loss and the recommendation for correction of the loss or medical referral is generally the duty of the audiologist, the speech pathologist is called upon to assist the patient overcome the language and speech problem that is many times associated with a hearing disorder. About five percent of Montana's children under 21 years of age have some type of hearing disorder. Many of these children have either language or speech problems or a combination of both.

c. Method

---Well-Child Clinics - Speech, language and hearing screening of every child over the age of 2 1/2 years is done. The speech pathologist is an important member of the team at well-child clinics. The children are seen at the clinic generally before they see the physician. If speech, language and/or hearing problems are found, the results are discussed with the physician before he/she examines the child. The speech pathologist can then discuss the problem and recommendations with the parents, physician and public health nurse. The child is generally referred to an agency providing speech correction or to one of the State Department of Health and Environmental Sciences mobile clinics.

---Nursing Conferences - As children are seen for nursing conferences, they will be given a speech, language and/or hearing evaluation by the speech pathologist. The results are to be discussed with the parents and the public health nurse. Recommendations are made for followup care. The child will be evaluated periodically. The child will generally be referred to an agency providing speech correction or to one of the department mobile clinics.

SECTION IV. DEMONSTRATION AND SPECIAL PROJECTS (Con't)

A. LANGUAGE, SPEECH AND HEARING PREVENTION AND CORRECTION PLAN (Con't)

2. Health Services Division - Maternal and Child Health Bureau (Con't)

c. Method (Con't)

---Education for Parenthood - Language, speech and hearing development are discussed with prospective parents. Some suggestions are given to the parents as far as some do's and don'ts for normal language, speech and hearing development. Certain developmental stages are watched. If the child does not meet these developmental milestones by a certain age, a language, speech and hearing evaluation is indicated. If the child needs speech correction, then it is arranged. Services nearest the patient's place of residency will be sought.

---Speech and hearing services can become an integral part of a maternal and infant care project. The main service that a speech pathologist could be is one of counseling the parents of infants about speech, language and hearing development and develop a program of preventing speech, language and/or hearing disorders. The State Department of Health and Environmental Sciences speech pathologist does consult with the speech and hearing clinician at the Lewis and Clark County Child and Youth Project.

---The hearing conservation program is a joint effort between the Maternal and Child Health Bureau and the Preventive Health Services Bureau. Assistance is given by the Nursing Bureau and Health Education Bureau. Approximately five to ten percent of all children who have a measurable hearing loss will probably have a speech and/or language disorder due to hearing loss. The audiologist generally recommends correction for the hearing disorder and speech correction for the associated speech and/or language disorder. There is an unestimated number of children who have normal hearing acuity but still have auditory problems. Many times these children are erroneously diagnosed as mentally deficient, emotionally disturbed or spoiled (disipline problem). These diagnoses may not be entirely correct. The speech pathologist and the audiologist, together with medical and educational specialists, are able to more adequately diagnose the problems and recommend an acceptable plan of correction. Speech correction is generally indicated. A referral is made to the speech pathologist nearest the residence of the patient.

SECTION IV. DEMONSTRATION AND SPECIAL PROJECTS (Con't)

A. LANGUAGE, SPEECH AND HEARING PREVENTION AND CORRECTION PLAN (Con't)

---Cleft Palate Program - Normal or near normal speech is one of the essential goals of the cleft palate program. All team members are very much interested in speech and language. The speech pathologist then is an essential member of the cleft palate team. The Montana cleft palate program provides speech and/or language consultation for all children born with a cleft lip and/or palate. Many of these children (about 75 percent) need a certain amount of speech correction. Speech correction may vary in length of time from one session to counseling with the parents to an extended series of correction. Arrangements are made, when possible, for the child to receive speech correction in or near his home community.

---Center for Handicapped Children - Diagnostic and evaluation clinics are held at the Center for Handicapped Children in Billings for orthopedically handicapped children. Each clinic has a team consisting of an orthopedic surgeon, a pediatrician, physical therapist, occupational therapist, speech pathologist, psychologist, audiologist, educational consultant and a public health nurse. There is also a social worker at the Center.

A mental retardation clinic is held monthly consisting of pediatrician, educational consultant, speech pathologist, audiologist, psychologist, and public health nurse. Occupational therapists and physical therapists are consulted when indicated.

Each week a speech clinic is held including the speech pathologist, audiologist, psychologist and public health nurse. Among the goals of the center are evaluation of children for language, speech, and hearing disorders, providing speech correction for those children enrolled in the school's special education program, providing speech correction for other children as time permits, and providing the necessary consultation for parents of children suspected of speech, language, and hearing disorders. Referrals are made to agencies nearest the residence of the patients for speech and hearing therapy.

SECTION IV. DEMONSTRATION AND SPECIAL PROJECTS (Con't)

A. LANGUAGE, SPEECH AND HEARING PREVENTION AND CORRECTION PLAN (Con't)

2. Health Services Division - Maternal and Child Health Bureau (Con't)

c. Method (Con't)

The speech pathologist is an important member of the various diagnostic teams at the Center for Handicapped Children.

---Crippled Children's Program - The Crippled Children's Program in Montana is designed to help families of handicapped children provide the care needed to give the child the best possible change to function at his/her highest level.

Speech therapy is a very important function in Crippled Children's Services. Many children having a speech, language, or hearing disorder are classified as "crippled." The speech, language, or hearing disorder may be the primary or secondary "crippling" condition. In order to help these children function at his/her highest level of function, speech correction is usually necessary.

---Speech Clinics (Mobile) - The objectives of the mobile speech clinics are to identify the child with a speech problem, language disorder, articulation disorder, voice disorder, and/or stuttering disorder, identify the adult (over 18) who has a speech problem and to provide a clinical correction (speech correction) program under the direction of a speech pathologist for those children and adults needing speech correction.

The activities of the mobile speech clinics are to screen all pre-school children (day care centers, vision screening, private and public kindergartens, and publicity through local service groups), screen the local public and private schools that do not have access to a speech pathologist, provide consultation to local hospitals, nursing homes, extended care units, retirement homes, etc., act as a referral source for physicians and public health nurses, develop a correction program for case load, coordinate activities with local speech pathologists and utilize all facets of mass media to publicize the speech services available.

Evaluation will be made by the percentage of children screened for speech problems, number of children

A. LANGUAGE, SPEECH AND HEARING PREVENTION AND CORRECTION PLAN (Con't)

2. Health Services Division - Maternal and Child Health Bureau (Con't)

c. Method (Con't)

needing speech correction but not able to receive this service, a review of records, and the number of adults referred for services.

3. Preventive Health Services Bureau

The majority of the speech, language and hearing disorders generally occur among the older citizens. These disorders generally include, but are not limited to, stroke, cancer, voice disorders (benign growth), speech and/or language disorders secondary to loss of hearing, and other disorders. Montana's population of citizens over 45 years is 209,734 or about 32 percent of the total 1970 population. This age range is more prone to stroke and cancer than any other age range. The biggest percentage of the speech pathologist's adult case load will consist of speech, language and hearing disorders relating to stroke or laryngeal cancer. These disorders become more critical when the population over 65 years (68,376 or about 10 percent of the total 1970 population) appears to be increasing. Indications are that over half the senior citizens choose to retire in small communities of less than a 50,000 population. Generally, there are no speech and hearing correction services easily available.

The objective would be to change the philosophy of care for adults, especially speech correction as part of patient services, to include, but not limited to, the following categories:

a. Stroke - Many of the patients who suffer from a stroke generally have a speech and/or language and/or hearing disorder. This disorder may be accompanied by other changes such as psychological, mental and physical changes. There is very little service available for the stroke patient in the state for speech, language and hearing. It is a problem of qualified manpower and placement. Very few of the speech pathologists in the state of Montana are trained to provide these services to the stroke patient.

Teams may need to be organized, including physicians, speech pathologists, physical therapists, occupational therapists, social workers, psychiatrists, psychoanalysts, vocational rehabilitation counselors and others to educate the professionals on the local level to work together for maximum

A. LANGUAGE, SPEECH AND HEARING PREVENTION AND CORRECTION PLAN (Con't)

3. Preventive Health Services Bureau (Con't)

rehabilitation of the stroke patient. Plans should be made to include speech, language and hearing correction to these citizens of Montana. Efforts should also be made to treat the family as well as the patient.

b. Cancer - The speech pathologist is an important member of the cancer control team. About 4,000 persons yearly have lost their voice, generally through laryngeal cancer. The ratio is ten men for every one female with the majority of patients between 40 and 60 years of age. Eighty-seven percent of these patients are able to learn to use esophageal speech and return to their original employment with the help of a speech pathologist. Cancer of the mouth may cause some speech disorders, especially when the tongue is removed. The speech pathologist is generally the one who teaches the cancer patient esophageal speech. Currently, there are very few speech pathologists in the state who have been trained to work with these patients. Cooperation must be maintained with the Cancer Society to find those persons in speech pathology who have been trained to help these patients learn to speak again. These adjunct personnel can be very helpful. More services are a must for these patients.

c. Voice Disorders (benign, nonorganic) - There are needs demonstrated for speech correction for patients with non-organic etiology. Several referrals have been received from ear, noise and throat specialists in the state. A speech pathologist could recommend speech correction upon referral from the physician.

d. Speech and/or Language Disorders Associated with Hearing Loss - These patients are generally referred by the audiologist. Speech correction generally entails introducing the recommending hearing aid, teaching speech reading, auditory training and articulation and other procedures that need to be started.

e. Other Speech, Language and/or Hearing Disorders - These may include disorders carried over from childhood such as cleft palate, cerebral palsy, or mental retardation or acquired traumatically such as an automobile accident or industrial accident.

SECTION IV. DEMONSTRATION AND SPECIAL PROJECTS (Con't)

A. LANGUAGE, SPEECH AND HEARING PREVENTION AND CORRECTION PLAN (Con't)

4. Hospital and Medical Facilities Division

The services provided by the speech program to this division are mostly consultation. The coordinator of the speech program is usually requested to determine if a speech pathologist hired by a hospital or nursing home meets the federal standards for speech pathologists established by the Department of Health, Education and Welfare.

5. Health Planning and Resource Development Division

The program for speech services coordinates the planning and implementation of services through the Health Planning and Resource Development Division. The division staff is generally available for consultation when needed.

6. Centralized Services Division

a. Health Education Bureau

Health Education Bureau assists in the educational programs established. The Health Education Bureau provides consultation on how to approach and start a program on the local level.

b. Nursing Bureau

Consultation is provided by the speech program to the Nursing Bureau on speech, language and hearing problems. It is planned to begin some in-service training to the nurses in screening potential speech, language and hearing disorders and make the necessary referral for further and more extensive evaluation. The Nursing Bureau, in return, provides consultation regarding child development and other problems related to speech, language and hearing development.

7. Services to Other State Agencies

Consultation is generally provided when other agencies request it. Some of these agencies are:

Department of Public Welfare
Department of Public Instruction (supervises the speech clinicians at Boulder and Eastmont Training Center)
Department of Public Instruction
Vocational Rehabilitation
Workmen's Compensation Division

SECTION IV. DEMONSTRATION AND SPECIAL PROJECTS (Con't)

A. LANGUAGE, SPEECH AND HEARING PREVENTION AND CORRECTION PLAN (Con't)

7. Services to Other State Agencies (Con't)

Employment Security Division
Commission on Aging
Office of Economic Opportunity
Federal and State Coordinator
Veterans' Welfare

B. Montana Center for Handicapped Children

The overall program of the Montana Center for Handicapped Children includes a school for handicapped children, therapies for the children, a teacher training responsibility, and a clinical program. Diagnostic and evaluation Medical Clinics are conducted with a basic philosophy of the team approach. The Medical Clinic team consists of an orthopedist, a pediatrician, a public health nurse, a psychologist, a speech therapist, a physical therapist, and an occupational therapist. Mental Retardation Evaluation Clinics are staffed by a pediatrician, a public health nurse, a psychologist, and a speech therapist. A full-time social worker is also on the staff.
The Center is sponsored by three agencies: The State Department of Health and Environmental Sciences, Eastern Montana College, and Billings School District. The State Department of Health and Environmental Sciences and Billings School District contracts with Eastern Montana College to carry out the Center's Program.

a. Goals

1. To provide a special education academic school program for children with physical and medical handicaps, multiple handicapping conditions and communications disorders to prepare these children to function in society to the best of their ability.

2. To provide the appropriate therapies for the children enrolled in the Center Special Education School program including physical therapy, occupational therapy, speech therapy, and play or psychotherapy.

3. To provide these therapies to other children as time permits.

4. To provide educational and training opportunities for college students studying in the area of Special Education.

5. To provide orientation and observation opportunities for nurses and various therapists in training.

6. To provide diagnostic and evaluation services for children with physical and medical handicapping conditions from throughout the State, for children with speech and hearing problems from the eastern portion of the State, and for preschool children suspected of being mentally retarded in the eastern portion of the State, and counseling for the parents of these children.

7. To make recommendations, suggestions and referrals for the most appropriate treatment, therapy, and/or training for the children seen in the clinic program.

SECTION IV. DEMONSTRATION AND SPECIAL PROJECTS

B. Montana Center for Handicapped Children

b. Needs and Problems

A new Special Education Building has been constructed on the campus of Eastern Montana College of Education. The ground floor of this building provides the housing for the Montana Center for Handicapped Children, allowing for much better utilization of the program in the college teacher training program, and expansion of the program with relation to handicapped children with a much more efficient and adequate facility in general. Occupancy of the new building began in November of 1972. We expect closer coordination and cooperation with other programs in Eastern Montana College and, if possible, some joint assignments of personnel.

Need for Improved Information Regarding Services

There still exists a need for an effective means of informing the people of the State - including professionals, agencies, and the general public regarding the existence of the program and the services available.

Care After School Age

A more effective program of occupational training including a sheltered workshop program for physically, medically, emotionally, mentally and multiply handicapped individuals is most urgently needed.

c. Methods of Attaining the Goals

A Special Education School Program is provided for the preschool children and elementary level children assigned through the Medical Clinics.

Occupational therapy, physical therapy, speech therapy and play or psychotherapy are provided for the children enrolled in the school program as required. College students training to become special education teachers are assigned to the two classrooms as interns, or are allowed to participate in the program as volunteers or as paid workers under the Work-Study Program. Other students are invited to visit the classrooms for observation periods.

The staff of the Center participate in the State Cleft Palate Program to provide the most adequate diagnosis, evaluation, treatment and therapy possible for these children.

B. Montana Center for Handicapped Children

c. Methods of Attaining the Goals (Cont'd)

Speech and hearing evaluation clinics are conducted regularly to provide the best diagnostic and evaluative service to the children of the eastern part of Montana.

d. Measures of Progress, Evaluation and Plans for Extension

A high percentage of the children who are enrolled in our Special Education Academic School Program are able to return to their home communities and enter regular school programs or special education classes.

An increasing number of college students are being assigned to training stations in the Center.

Each term, groups of student nurses and graduate nurses receive orientation presentations and observe and participate in clinic activities. Many high school students and college students have an opportunity to participate as volunteer classroom aides, therapy aides, and in special activities with the children. College students are assigned in work-study programs and gain experience in working with the handicapped.

SECTION IV. DEMONSTRATION AND SPECIAL PROJECTS

C. CLEFT PALATE PROGRAM

1. Need for the Program

Montana is the fourth largest state with 147,138 square miles. The 1972 population was estimated at 700,000. The average population density is five people per square mile. The major population centers are located in Cascade, Yellowstone, Silver Bow, Missoula, Lewis and Clark, Gallatin, and Flathead Counties.

The majority of the medical and dental specialists reside and practice within the boundaries of these seven counties. In many of the sparsely populated counties there is a shortage of adequate medical and dental personnel. There are public health nurses located in most of the counties in the State. However, most of these nurses have a rather large territory to cover as well as a large caseload. With this shortage of medical, dental, and nursing personnel in the rural area; many Montana residents must travel great distances to obtain the necessary medical and dental care. If a medical or dental specialist is required, then travel is frequently increased due to necessary repeat visits. This is especially true for families who have children born with a cleft lip and/or palate.

Prior to 1955 the habilitation of children born with cleft lip and/or palate in Montana was part of the general services offered by Child Health Services (Crippled Children's Services). The Child Health Services staff was at this time aware that the services available were nonexistent in certain areas of the total treatment spectrum. In reviewing these services, four major disadvantages were identified:

A. Due to a lack of knowledge and coordination in the medical and dental specialties within the State, much of the treatment to correct the palate was referred to out-of-state facilities. This was found to be an extremely expensive program both to the parents and Child Health Services. In some instances the cost was prohibitive.

B. Although obtained surgical services were of the highest quality, there was generally a lack of coordination of services in achieving maximum habilitation with the multiple problems presented by a child with cleft lip and/or palate.

C. Since surgery was generally the only restorative measure used for all cases, the overall functional result left much to be desired; such as, cosmetic appearance; maxilla-mandibular relationships; general dental conditions; malposed, missing, and misplaced teeth; adequacy of palatal pharyngeal closure; and communicative speech ability.

D. Follow-up care was ineffective in providing adequate habilitation, particularly so for children receiving surgical care from out-of-state facilities. This, in part, may have been due to poor communication between the out-of-state professionals and the

SECTION IV. DEMONSTRATION AND SPECIAL PROJECTS

C. CLEFT PALATE PROGRAM

1. Need for the Program

in-state agencies involved in the treatment of the child with cleft lip and/or palate. It was noted that children receiving treatment services within Montana did obtain better follow-up services than children receiving treatment from out-of-state services. However, since the follow-up services were not coordinated by a specific group or single agency, some children were receiving sporadic or no follow-up from their local physicians, dentist, or public health nurse. Those children born with clefts who did not receive services within the State were cared for by an interested surgeon with minimal financial assistance from Child Health Services. Thus it was deemed necessary to give one central agency the responsibility of administering the program which included consistent and concentrated follow-up care. (Program plan January 9, 1956).

E. Realizing the need for long-term care (0-21 years of age) of the child born with this handicap and the expense involved, the application was made and a grant was issued July 1, 1956, to the state of Montana. Since there is no medical school available in Montana where cleft palate clinics would be an asset for training and where a conglomerate of medical and dental specialties would exist, the State Department of Health and Environmental Sciences took the responsibility for organizing the Program.

2. Legal Authority

There is a State Department of Health within the Executive Branch of State Government, Chapter 69-4101 RMC1947. The state board may accept and expand federal funds available for public health services, Chapter 69-4106 RMC1947 and develop and administer a program to protect the health of mothers and children, Chapter 69-4110 RMC1947.

3. Program Goal

To improve the health of the child born with a cleft lip and/or palate by coordinating with the family, the medical, educational, and social needs of the child from birth through age twenty-one at a cost not to exceed $250 per child per year.

A. Objective

To improve the health of the child born with cleft lip and/or palate in the medical, educational and social areas through the criteria developed below so that thirty percent (30%) of the children will see improvement in at least two of the following categories:

a. social skills
b. speech development
c. language development
d. hearing development
e. dental development
f. emotional adjustments when feasible

C. CLEFT PALATE PROGRAM (Cont'd)

B. Proposed Plan for the Project Period

Due to the past birth and other records, we expect between 16 to 24 children born each year with a cleft lip and/or palate. In addition we anticipate 10 to 15 children with a cleft lip and/or palate moving into Montana who will request services from the Cleft Lip and Palate Program.

GOAL

To develop early intervention programs in nutrition, social work, and program registration to the newborn with a cleft lip and/or palate to provide corrective treatment and supportive services to the newborn with a cleft lip and/or palate. (July 1, 1975 - July 1, 1978)

NEEDS STATEMENT

In the 1967 Montana Questionnaire Survey sent to parents of children for suggestions of possible improvement of services, instructions in feeding was, above; the most mentioned need. Feeding problems, anxiety of parents, and failure to thrive may be consequences of the lack of supportive nutrition instruction to parents of infants having a cleft palate. Other nutrition problems with infants or children having a cleft palate are dental caries, obesity, underweight,& surgical diets. Additionally lack of food planning, purchasing, preparation, and storage skills are more often lacking in young and/or low income mothers seen at the clinics. Therefore, if our goal and objective is to work with problems directly related to cleft palate conditions and to focus on the total needs of the individual, nutrition needs to be an integral part of the services in the Cleft Palate Program because of nutrition problems especially related to both areas. A brochure, "Feeding the Child With Cleft Lip and Palate," developed after the 1967 Montana Questionnaire Survey, stated that immediate feeding instructions were an unmet need of parents with newborn infants having a cleft palate. Additionally physician members of the Great Falls Cleft Palate Team have expressed that they have not seen or are not using the brochure. Also OB-GYN nurses of one of Great Falls leading hospitals have never seen the brochure. An evaluation of the brochure with parents has not been conducted. Moreover, a need exists to ascertain if parents receive the brochure and what, if any, supportive services are given to the parents regarding feeding instructions and are these adequate.

Objective 1: By the end of fiscal year 1976, an assessment and evaluation will be made of the instructions and supportive services given to parents of newborn infants having cleft palate to ascertain if nutrition instructions are adequate, and if not, a plan is to be implemented in Fiscal Year 1977 to correct deficiencies that may exist. Additionally, a reevaluation of the corrective plan in Fiscal Year 1978 will be conducted.

C. CLEFT PALATE PROGRAM (Cont'd)

Objective 2: By the end of Fiscal Year 1976, possibilities of developing various audio-visual teaching aids in feeding instructions with the cleft palate infant with appropriate hospital and public health professionals and particularly parents will be fully developed by the social worker and public Health nutritionist with the Great Falls Cleft Palate Program.

Objective 3: By the end of Fiscal Year 1977, various audio-visual aid materials will be developed, used, and evaluated for in-service training of related health professionals at specific hospitals and public health departments within the Great Falls Cleft Palate Program.

Objective 4: By the end of Fiscal Year 1978, the final copies of the "tried and tested" audio-visual aids materials will be reproduced for major hospital and public health departments in the State and introduced throught in-service training.

(b) Referrals for social work services leaves a lot to be desired in the health field. Ideally the social work component within the Health Department should be able to provide direct counseling services to cleft lip and/or palate clientele throughout the State. Not all families require intensive counseling but many need the kind of supportive services social workers and public health nurses can offer while they are dealing with their child's condition. With some of these children, their condition will require years of specialized care including medical, educational, social, psychological, and financial.

With preventive intervention by social workers and public health nurses, families can be helped to handle a multitude of feelings they experience when their child is handicapped. They also need to know about available and appropriate resources as many individuals are not able to meet catastrophic and long-term care. Just to know about available financial programs can often keep a family for panicking.

Social work services need to be an integral part of the team approach in the service system as social work can provide information regarding family interaction and interrelationships which have a direct relationship on the family's ability to utilize available resources to the best advantage of their child.

Most social workers in the State of Montana are employed by Social and Rehabilitative Services and the Department of Institutions, the Mental Health Clinics, After Care Division, and probation and social work services to the residents of Boulder (institution for the retarded) and Warm Springs (institution for the mentally ill).

C. CLEFT PALATE PROGRAM (Cont'd)

There are a few medical/social workers located in the hospitals and they are pretty much limited to providing social work services within their community and related to the individual's hospitalization.

The Department of Health has four social workers employed; one on the State level who is the cleft lip and palate coordinator and three who are each in special projects; the Maternal and Infant Special Project, Children and Youth Project, and the Center for Handicapped Children. Only one social worker (at the Center) is able to provide limited social work services to the Center's clientele.

The problem is referring clients with a health problem where there may be some social/emotional interaction intensifying the problems to Welfare or Mental Health are as follows:

1a) Social and Rehabilitative Services can provide services if the family is eligible to receive a categorically related service. Many of our cleft lip and/or palate families are above Social and Rehabilitative Services financial eligibility and therefore, the referral would be inappropriate. The families themselves do not want to be referred to Welfare mainly because of the stigma attached. They feel they are not that bad off and even though it may be for social work service only, the stigma often handicaps the social worker's ability to work with the family.

Many social workers with Social and Rehabilitative Services do not have very much information relating to the intertwining of social/emotional and the effect of handicapping conditions or illness on human behavior. Many times people are approached with a tendency on the social worker's part that the defined problem stems from the sociological aspects. This is not entirely the social worker's fault as our basic social work education does not emphasize the medical aspects which may alter an individual's behavior and a family's approach to this individual.

Due to the limited Social and Rehabilitative worker's time, many referrals from Child Health Services could not be given the intensive casework services and follow-up often required by the situation. Social and Rehabilitative Service workers tend to provide services on a crisis intervention basis due to the lack of staff and the large number of a certain type of clientele.

2a) Mental Health Clinics are scattered over the State and many individuals are required to drive long distances for services. Again mental health has a certain stigma attached to mental health and people in smaller communities are hesitant in utilizing this resource. Many Montanans feel that a person is very "ill" and weak if they resort to Mental Health Clinics. There is a lot of educational activity regarding preventive mental health care. In due time we may see more willingness to utilize this resource before the problem becomes very serious.

C. CLEFT PALATE PROGRAM (Cont'd)

Again Mental Health Clinics tend to approach their clients with a greater emphasis on the social/emotional base with less importance given to the medical component in working with some of these families.

Means to effect change: Some inservice education has been initiated with Social and Rehabilitative staff. Brief cleft lip and palate presentations have been made to various Social and Rehabilitative staff but by no means does this begin to cover the need to help social workers within this agency to broaden their knowledge about the impact a disease and handicapping condition can have on a family and the client.

There is a possibility of providing a semester's course on medical/social work at a small private college located in Montana which has an accredited undergraduate social work curriculum. This will depend upon a special grant being funded. Presently a presentation is made each semester regarding the Child Health Services Program and the Cleft Lip and Palate project which stimulates many questions regarding the role of social work in the medical field.

The need for field social work to be an integral part of the Child Health Services is known. However, money and program priorities may put the actual hiring individuals to provide these needed services way into the distant future.

In the meantime as problems are identified, the individual and their parents are offered the various available referral sources and encouraged to seek follow-up services. Of course, there are those instances which do exist when a referral is made directly to the Child Welfare Service due to the nature of the problem without the parental consent.

Child Health Services is also defining its role in working with Developmental Disability Bureau within the Social and Rehabilitative Services, which is supposed to provide services to individuals with cerebral palsy or mentally retarded and others with certain handicapping conditions.

The schools are often another resource utilized by Child Health Services to provide social work services or counseling services to a school age client. This resource is limited as it depends a great deal on what counseling or social work services are offered by the individual schools. The situation has a lot of room for improvement but I do believe when a situation arises that really demands attention, there is some available resource to assist. It's the area of preventive social work services where families receive support before the situation develops into a serious situation that we are unable to address ourselves at this time.

C. CLEFT PALATE PROGRAM (Cont'd)

To develop better case finding techniques to insure Program registration for children with cleft lip and/or palate who have not received any previous services from the Program but who could benefit from the comprehensive approach to treatment utilized by the Cleft Lip and Palate Program. (1975 - 1976)

Development of a public relations component for the Cleft Lip and Palate Program for the expressed purpose of informing key professionals of the services offered by the Program. (July 1, 1975 - July 1, 1976)

c. Knowledge of the Cleft Lip and Palate Program

Although the Cleft Lip and Palate Program has operated within Montana for some 21 years, there still exists a general lack of knowledge about the Program in various areas.

Children born with cleft lip and/or palate in Montana may not always be referred to the Program by the individual doctor for various reasons, but information is available to this office by reviewing birth certificates which are routed to our office by Vital Statistics.

Public health nurses and physicians familiar with Child Health Services are the biggest referral source to the Cleft Lip and Palate Program.

The areas we've identified to work with in making our services more uniformly known are: 1) Social and Rehabilitative Services social workers, 2) school officials (classroom teachers, speech therapists), 3) OB wards in local community hospitals, and 4) information available to new physicians in the State.

The problems to overcome in making information available are the following: 1) unless the need arises, quite frequently the tendency is the material is thrown away or filed away and forgotten, 2) it may never reach the physician as his secretary has been told to screen his mail.

Things being done

(a) Inservice training with Social and Rehabilitative Services workers regarding Child Health Services and the Cleft Lip and Palate Program and Heart Center services.

(b) Child Health Services procedure manual was developed and mailed to program physicians, public health nurses, and selected Social and Rehabilitative Services offices. (Social and Rehabilitative Services county offices act as referral agents in areas where there is no county health nurse.)

C. CLEFT PALATE PROGRAM (Continued)

4. PROGRAM STRUCTURE

The Cleft Palate Program is an integral part of the Maternal and Child Health Bureau which is located in the Health Services Division of the Department of Health and Environmental Sciences. The funding for the Cleft Palate Program is from the Department of Health, Education, and Welfare and from the State of Montana.

Why a Team Approach

One of the most outstanding surgeons of recent years said after his retirement, "If I had to go back to practice in the field of cleft lip & palate surgery, I would not be willing to do so in any other way than through the multidiscipline approach." (Ivey, R.H. J. American Medical Women's Association, 21: 196: 1966)

An impressive feature of congenital craniofacial deformities is the multiplexity of impairment which they induce. The primary goal in the treatment of children with these disorders is the reduction of the disabilities which accompanies them, and the alleviation of the personal and social handicap they impose. Few clinical situations provide more persuading evidence of the need to serve the total, the whole, patient.

The multidisciplinary team is the logical response to this need. Effective and economical habilitation of the patient with congenital craniofacial disorder requires a wide variety of specialized knowledges and skills. These can best be expressed through a cooperative effort that exists in a true functioning team.

The team has been described as a close, cooperative, democratic, multi-professional union devoted to a common purpose - the best treatment for the fundamental needs of the individual.

The team organization makes possible a diagnosis derived from broader more accurate sources of information and more representative judgements and decision. The treatment resulting from a group plan is more likely to assume a proper sequence and balance. The team properly staffed, organized, and conducted is not the product of mere physical collecting of specialists in the same room. It has the ability to be more than just togetherness. It is a system in which all serve a common and improved end. It is self-correcting through feedback to the end that all are controlled in terms of their relationship to each other and to the purposes of the whole system.

It became evident that a single specialty was both inappropriate and inadequate for the achievement of the larger goals of habilitation that had become so apparent as the result of our expanded understanding of the nature and of the implications of this deformity. It became obvious that since the specialist is dealing with a growing, developing, and changing child, the proper ordering and timing of specialistic efforts was particularly imperative.

C. CLEFT PALATE PROGRAM (Continued)

Also the physical, intellectual, and social maturation of the child requires a more complete and careful plan of treatment. The child with cleft lip and/or palate requires a closer but time-adjusted integration of specialistic efforts. More than this, the condition demands that diagnosis and treatment be the product of the experienced and informed interaction of a team of specialists.

Those who don't receive this type of coverage often receive fragmented and partial treatment. Often the different types of care given will work against each other, such as orthodontics against surgery if surgery is done at the wrong time. The overall general results often are not as good as they otherwise could have been. As pointed out earlier in this section the team approach is better because they are concerned about the whole child, not just the cleft. The patient is first a child, then a child born with a handicapping condition. The whole child includes the child's total environment as much as possible.

State Level Personnel

The Chief of the Maternal and Child Health Bureau has a Doctorate of Medicine Degree. He approves all major changes and gives direction when necessary.

Coordinator of the Cleft Palate Program is responsible for:

a. Planning a state-wide program for the maximum habilitation of children born with cleft lip and/or palate which includes but is not limited to involving the children born with a cleft lip and/or palate with the Program so that the child and family may have the opportunity to receive maximum benefits from coordinated services.

b. Coordinates the Cleft Palate Program and the Cleft Palate Teams.
Acting as a liason among the team members between the four teams and between state and local health professional staff.

Consolidating each team member's report on the evaluation of the child who had been examined at clinic and summarizing the final team discussion as to the recommendations of treatment.

The parents of the child are informed by follow-up letter the complete team evaluation and recommendations. The recommendations are explained in a step-by-step process and should the parents have questions, then they are free to contact the Cleft Lip and Palate Coordinator.

The family physician and dentist and other necessary local personnel are informed of the team recommendations. This is an important avenue of communication to maintain the involvement of the local professional personnel with the care of the child.

SECTION IV. DEMONSTRATION AND SPECIAL PROJECTS

C. CLEFT PALATE PROGRAM (Continued)

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C. CLEFT PALATE PROGRAM (Continued)

Also the physical, intellectual, and social maturation of the child requires a more complete and careful plan of treatment. The child with cleft lip and/or palate requires a closer but time-adjusted integration of specialistic efforts. More than this, the condition demands that diagnosis and treatment be the product of the experienced and informed interaction of a team of specialists.

Those who don't receive this type of coverage often receive fragmented and partial treatment. Often the different types of care given will work against each other, such as orthodontics against surgery if surgery is done at the wrong time. The overall general results often are not as good as they otherwise could have been. As pointed out earlier in this section the team approach is better because they are concerned about the whole child, not just the cleft. The patient is first a child, then a child born with a handicapping condition. The whole child includes the child's total environment as much as possible.

State Level Personnel

The Chief of the Maternal and Child Health Bureau has a Doctorate of Medicine Degree. He approves all major changes and gives direction when necessary.

Coordinator of the Cleft Palate Program is responsible for:

a. Planning a state-wide program for the maximum habilitation of children born with cleft lip and/or palate which includes but is not limited to involving the children born with a cleft lip and/or palate with the Program so that the child and family may have the opportunity to receive maximum benefits from coordinated services.

b. Coordinates the Cleft Palate Program and the Cleft Palate Teams.
Acting as a liason among the team members between the four teams and between state and local health professional staff.

Consolidating each team member's report on the evaluation of the child who had been examined at clinic and summarizing the final team discussion as to the recommendations of treatment.

The parents of the child are informed by follow-up letter the complete team evaluation and recommendations. The recommendations are explained in a step-by-step process and should the parents have questions, then they are free to contact the Cleft Lip and Palate Coordinator.

The family physician and dentist and other necessary local personnel are informed of the team recommendations. This is an important avenue of communication to maintain the involvement of the local professional personnel with the care of the child.

C. CLEFT PALATE PROGRAM (Continued)

In cooperation with other state and local personnel to develop an educational program that will upgrade the services provided by the program personnel.

Attends and conducts clinics to assure the clinic functions smoothly and that the children and parents are given a thorough evaluation.

Collects all necessary background information from health and educational agencies.

Organizes the team meeting, invites the children to attend, and assists the family in obtaining the necessary follow-up care.

The secretary must meet basic experience and educational requirements established by the State. This individual assists the coordinator, does the necessary secretarial duties, and assists at clinics by functioning as the clinic receptionist.

The social work consultant has a Masters in Social Work and has been employed since June 1973. The responsibilities for this individual are the following:

Participates as the clinic social worker with the Missoula and Helena Cleft Lip and Palate Teams. In this role the individual is responsible for identifying problem areas in social/emotional functioning with the child and/or with his family.

Coordinates the referrals of the child and/or family to the appropriate local resources for assistance in dealing with the identified social/emotional problems. Also obtains the results of services provided and in those cases where the service is being offered for a long-time period, obtains brief summaries of progress reports.

Compiles the social service summaries from other agencies and makes the information available at the clinics.

Acts as liaison between local and state agencies to improve coordination of services for the cleft lip and palate child and his family.

Acts as a liaison between the client and family and the Cleft Palate Teams.

Works closely with the two social workers hired on a contracted basis in Billings and Great Falls.

Assists the coordinator as assigned.

SECTION IV. DEMONSTRATION AND SPECIAL PROJECTS

C. CLEFT PALATE PROGRAM (Continued)

CLINICAL TEAMS
Each team consists of the following members:

1. Project Coordinator
2. Plastic Surgeon
3. Ear, Nose, and Throat Specialist
4. Pediatrician
5. Orthodontist
6. Pedodontist - Prosthodontist
7. Social Worker
8. Speech Pathologist
9. Audiologist
10. Nutritionist
11. Public Health Nurse

The Billings Cleft Palate Team is the only one to have a psychologist on staff.

Each individual offering services to the team is doing so out of special interest in working with the cleft lip and palate child. Most of the team members have had varied training experiences in working in this problem area. Due to the small population of patients with clefts in Montana, these professional are able to maintain their knowledge and expertise levels by participating in this Program as they are able to see a larger number of children. This also allows the team to meet on a regular basis and facilitates continued communications regarding services. These individuals usually make special efforts to obtain new information regarding cleft lip and palate treatment by attending special meetings and reading current literature.

Clinical Social Work Consultant
Two individuals are contracted to provide diagnostic evaluations in the area of social/emotional dysfunctioning. Both of these individuals have their Masters in Social Work and have provided this service with the local Cleft Lip and Palate Team for several years.

The social worker with the Billings Cleft Lip and Palate Team is responsible for the diagnostic evaluation at clinic. In addition to the evaluations and referral recommendations, this individual is able to perform unique services to the child and his family during the time they come in for surgery. This individual is employed by the local hospital utilized by the team surgeons. With cooperation from and coordination with the surgeons, the families are given counseling services, supportive services, and limited follow-up services upon return to their home.

The social worker with the Great Falls Clinic provides the diagnostic evaluations during clinics. Because of his regular job setting with the Mental Health Clinic, he is in a position to provide intensive counseling services to families and their children when such a referral is indicated. It has been found this relationship does improve the family and child's involvement and concern for their responsibilities

C. CLEFT PALATE PROGRAM (Cont'd)

in working with the team's recommendations. He also has been valuable in working with the other local resources as he is able to act as coordinator on a local level.

Both social workers will refer families who require follow up who do not live in their vicinity to the Maternal and Child Health Bureau social worker to arrange for the necessary services.

Audiologist

The teams are covered by the two Department of Health audiologists. Children born with clefts tend to have more hearing disorders than children who do not have clefts. Through the use of highly sophisticated equipment, the audiologist is able to maintain a graphic picture of the child's hearing curve. When the curve deviates from the normal limits, then referral for proper medical treatment is necessary. If medical intervention is unsuccessful then the audiologist will through the application of highly technical skills fit a hearing aid to the child.

Nutrition Consultant

A public health nutritionist is a full-time employee of the Maternal and Child Health Bureau of the Department of Health and Environmental Sciences. With schedule allowing, the public health nutritionist is a team member of the Cleft Palate Program. A local nutritionist has been employed on an hourly basis on the Great Falls Cleft Palate Team.

Otolaryngologist (ENT)

When the program was implemented, certain Ear, Nose, and Throat specialist were placed on the team. These were specialists who had received their ear, nose and throat training at Iowa because this is the only medical facility where ear, nose and throat residents get training in cleft palate repair. These individuals had to fill a dual role as ear, nose and throat and plastic surgeons because there were no plastic surgeons in the State until 1972. The only ear, nose and throat man doing cleft palate surgery now is in Billings. He will continue in this dual capacity until he resigns from the Cleft Palate Program.

As mentioned earlier children born with a cleft lip and/or palate are very susceptible to middle ear disease. The Ear, Nose and Throat is the medical specialist best qualified to treat middle ear disease. If middle ear disease is left untreated, permanent hearing loss usually occurs. A loss of hearing of over 30% can be very detrimental to a child. The learning process may be interfered with because the child does not hear or understand all the necessary information for normal learning. Most of the time if it is detected soon after onsent, middle ear disease can be treated so that there is no permanent damage to the hearing mechanism. There is a certified Ear, Nose and Throat person on each team.

C. CLEFT PALATE PROGRAM (Cont'd)

Orthodontist

Each team has an orthodontist as a member. He may or may not provide the active orthodontic treatment but his recommendations are followed by the family's orthodontist. The orthodontist's role is essential in achieving maximum correction of the cleft lip and/or palate congenital defect. Each patient with a cleft lip and/or palate exhibits marked differences in their own maxillofacial growth and development depending on the type and severity of the deformity. Any number of the following dental problems may be present:

1. an increase in the number of congenitally missing teeth, especially in the back segments of both the maxillary (upper) and mandibular (lower) arches
2. supernumerary teeth
3. fused teeth and irregular tooth size
4. malformed teeth
5. malpositioned teeth
6. delayed eruption of teeth, especially the upper canine on the side of the cleft
7. over-eruption of the lower anterior teeth

The treatment and correction of these problems is the responsibility of the orthodontist. A certified orthodontist is on each team.

Plastic Surgeon

The surgical correction of the child born with cleft lip and palate requires very technical surgical training, especially in regards to head and neck and "cosmetic surgery." The plastic surgeon is best trained to handle this problem. Each team is staffed with plastic surgeons.

Pediatrician

Each team has a pediatrician attending clinic. This individual is a specialist in child medicine and is responsible for the general physical exam, eliciting immunization history, and diagnosing any health problems at the time the child is at clinic. This individual is responsible for the overall health assessment of the child.

Since the team pediatrician may not be the family's selected doctor, his findings and recommendations are utilized by the team in the overall diagnosis and all information is forwarded to the family's physician for follow up. The family physician may at any time request an evaluation by the team or send pertinent information to the program coordinator or any other team member.

Prosthodontist - Pedodontist

Prosthetic intervention is indicated for feeding aids, special nipples for the newborn child, and in cases where surgical repair is not deemed advisable or practical; such as:

C. CLEFT PALATE PROGRAM (Cont'd)

1. children in poor physical health
2. large and extensive clefts of the hard and soft palate
3. extremely collapsed alveolar arches where surgery might exhibit growth and development of the maxilla
4. older teen-age and adult patients
5. patients in whom surgical closure has been attempted and has failed leaving one or all of the following conditions: residual perforations of the palate, velopharyngeal insufficiencies, immobility of the soft palate, and scarring and fibrosis of palatal tissue
6. patients in whom prosthetic and surgical techniques are employed together

The local family dentist provides the routine dental care. The Cleft Lip and Palate Team utilizes the family dentist to initiate a rigorous dental care program for the child as early as age one, instructing the parents in proper brushing and flossing; proper diet control; dental checkups every three months; regular regime of fluoridation application; and cavity detecting x-ray. The family dentist plays an essential role in watching and monitoring the teeth development and growth. He may request an evaluation from the team any time he feels there is reason to become concerned about the tooth development pattern.

It is a well-known fact that children born with clefts of the lip and/or palate tend to have more dental caries than other children. For this reason rigorous dental care is essential. When a cavity first appears it is repaired immediately instead of waiting until it is large. The prosthodontist-pedodontist works with the child and family to work out the cavity prevention program. Each team has a licensed dentist who is experienced in prosthetics and children's dentistry.

Speech Pathologist

The differential diagnosis of functional and organic causes of speech disorders and the correcton through therapy of functional speech abnormalities is the major concern of the speech pathologist on the Cleft Palate Team. Each team is staffed with an experienced certified speech pathologist. The major causes of communication disorders may be divided into two categories:

1. Organic factors which are defined as diagnosable structural abnormalities which when changed by physical management result in a direct measurable improvement in speech behavior. An example of organic factors would be the surgical closure of a perforation in the hard palate leading to immediate elimination of hypernasality.

2. Functional factors may be defined as all other presumed causes which are not directly treatable by physical management, such as habits, motor skills, etc.

C. CLEFT PALATE PROGRAM (Cont'd)

The team speech pathologist does not provide the follow-up speech therapy. The child is referred to a local therapist who provides the required therapy. The team speech pathologist usually acts as a consultant to the local therapist. The teams speech pathologist is also responsible for making certain correct referrals are made and follow-up information is sent to the Cleft Lip and Palate Program.

Public Health Nurse

The public health nurse is the liaison between the team, medical profession, and the family. The nurse visits the family in the home to determine the families health needs. In addition, the public health nurse is instrumental in coordinating the local services necessary to assist the child and family in obtaining maximal habilitation from his handicap.

Since some county health departments have several nurses on staff, each nurse is invited to attend clinic if she has any families from her service area scheduled for evaluation. During staffing she is given an opportunity to provide information she may have regarding the family and how she feels this may effect team recommendations.

When the family is attending clinic from out of county, the appropriate public health nurse is notified of the clinic appointment. If she has any pertinent information she feels the team needs for evaluation, she then forwards this to the cleft lip and palate team coordinator. The information is then discussed at clinic and the team evaluation and recommendations are sent to the appropriate public health nurse for follow-up services. Due to limited county budgets and other established priorities for the public health nurse's time, this system has proved to be quite effective for our State.

CLINIC CONDUCT

Each clinic is conducted in similar fashion with the exception of the Billings clinic. Each member uses a special form to fill out on each patient. Clinic appointments are made through the Cleft Palate Coordinator's office by sending the parents an appointment letter and a card to return indicating whether or not the child can attend the clinic.

a. Great Falls Team: The clinic lasts all day and is capable of evaluating between 8 - 11 children. Four or five children arrive at the clinic at 8:15 a.m. and are given a thorough evaluation by all team members. After the clinical exams have been completed, the team staffing begins.

SECTION IV. DEMONSTRATION AND SPECIAL PROJECTS

C. CLEFT PALATE PROGRAM (Cont'd)

The Great Falls Team meets one day each month in September, October, November, March, April, and May.

After each team member has reported his findings and recommendations, the team then agrees on recommendations as to what should be done, the priorities, when it should be done, and when we should invite the family back for another team evaluation. Then the patient and the parents are brought into the room with the team, and the recommendations are thoroughly discussed with the parents and the patient. The parents are given an opportunity to discuss their questions. They are then instructed that they will receive a letter from the Coordinator of the Cleft Palate Program reviewing the recommendations with them, telling them the names and addresses of individuals by whom they should be seen and giving them help in follow-up work. This letter tends to help improve our follow-up care. Typed reports are then sent to the family physician, dentist, public health nurse, and other personnel who might be working with the patient.

b. Billings Team: Billings procedure is the same as Great Falls. The Billings Team meets also during September, October, November, March, April, and May.

c. Missoula Team: Missoula meets once in the Fall and twice in the Spring. The procedure is the same as in Great Falls.

d. Helena Team: The Helena Team sees five children in the morning and five in the afternoon. The team discussions are quite similar. The team meets in September and October and once in the Spring.

ELIGIBILITY FOR CLEFT PALATE PROGRAM

Registration on the Cleft Palate Program is available to any child who resides in Montana who is born with a cleft lip and palate, cleft lip only, cleft palate only, submucous cleft, congenitally short palate, or congenitally insufficient velo-palatal closure. Registration is usually affective upon Child Health Services' receipt of the referral and the signed application for Child Health Services.

Because of the reputation of the Cleft Palate Program, babies are usually referred the day of birth to Child Health Services or through one of the team personnel. Children who move into the state are referred by the public health nurses in their counties or by a dentist, orthodontist, physician, speech pathologist, audiologist, school teacher, or other knowledgeable person who may come in contact with the children. In some instances family members or friends have referred the child to the Program. In addition some referrals are made to Child Health Services from Crippled Children's Services in other states. When a child who is registered on Montana's Program moves to another state, then that state is notified and necessary information is forwarded to them. In these referrals received from sources other than the child's physician, notice of registration is sent to the patient's physician so they may be aware of the services the child is receiving and can provide medical information to the team.

C. CLEFT PALATE PROGRAM (Cont'd)

Registration on the Cleft Palate Program is not restricted on the grounds of race, color, or national origin.

Team Evaluations

Each child registered on the Cleft Palate Program receives the team evaluations without charge, regardless of the parent's income. If special x-rays or study models are needed for the clinical evaluation, there are no charges made. However, because these special x-rays and study models are done outside of the Cleft Palate Clinic, we request that insurance benefits be used and the Cleft Palate Program will pay the balance. Thus we are able to provide special x-ray and study model services to more children at no cost to the families.

Financial Assistance

Registration on the Cleft Palate Program and Child Health Services does not automatically mean that the family is eligible for financial assistance for habilitative care beyond the team evaluations. Financial assistance for services such as hospitalization, surgical fees, and orthodontics is available to those who fall within the Child Health Services guidelines for financial services. Before the Cleft Palate Program can participate financially, the care must have been recommended by the cleft palate team, and the team approved persons providing the service must request and receive in advance the approval to use cleft palate funds for that service.

In order to apply for financial assistance the parents must have submitted an up-to-date social and financial study. They are requested to obtain from the local public health nurse the necessary forms and help in completing them. In the counties where there are no public health nurses, the families are referred to the county Social and Rehabilitative offices. In order to keep our record up-to-date, new social/financial studies are requested on a yearly basis.

Procedure for Issuing Authorizations for Financial Assistance

Authorization for services are made by the following Maternal and Child Health staff members. The project director has primary responsibility for issuing the authorizations. Should the project director be unavailable due to travel or illness, then the responsibility is delegated to the Administrative Assistant/Child Health Program Director. The third backup individual responsible for issuing authorizations is the Bureau Chief of Maternal and Child Health. The Child's parents are encouraged to pay for the recommended care whenever possible. Occasionally parents want to share the expense for care, such as orthodontics or dentistry. These arrangements have been very successful. Generally speaking in terms of where the Child Health Services participates with the Cleft Palate Program in sharing expenses, the Program will authorize the initial payment, for example; orthodontics and the patient's parents pay the monthly maintenance and adjustment fees. Parents are requested and required to utilize insurance benefits wherever applicable. Title XIX monies are also used where applicable.

C. CLEFT PALATE PROGRAM (Cont'd)

The authorizations for care must be preauthorized and are authorized only for one particular phase of treatment at a time. If a new phase is initiated, then reevaluation of the parents financial structure is completed. The Cleft Palate Program does not authorize for services rendered outside the state of Montana unless that patient has been referred to the out-of-state source by the Cleft Palate Team.

Types of Services the Program Will Pay For

The Cleft Palate Program is able to pay for surgical fees, hospital, orthodontics, prosthodontics, and anesthesiology associated with cleft palate habilitation. These fees are paid directly to the vendor after insurance benefits have been utilized.

Cost of Program

Medical and dental costs are continually rising. Inflation for the medical and dental care is an impairment to a fixed budget. The Program is being forced to financially assist fewer children who actually need assistance.

The State Department of Health and Environmental Sciences had adopted the MMA Relative Value Schedule. The Department, however, does not pay the current rate, but does pay a negotiated rate. This fee schedule has also placed some stress on the Program in the additional cost for surgeries. Hospital rates continue to be on the increase; they have increased approximately 43% since 1966. During 1967 the Montana hospitals refused to accept payment from Crippled Children's Services for children who were eligible for financial assistance. The hospitals felt that the per diem rate which we were paying at that time was not a fair fee. It was determined that Crippled Children's Services would pay the hospital cost the same rate as Medicaid (Title XIX). Since 1967, Child Health Services has been paying "billed charges" with adjustment to reasonable cost at a later date. Each year the hospital costs have risen. If hospital rates continue to inflate as rapidly for the next four years as they have for the past four, the Program can expect to spend well over $200 a day for cleft palate surgery.

Dental and prosthetic fees have also increased. In 1972, the dentists and prosthodontists have adopted a Relative Fee Schedule which has been accepted by Crippled Children's Program. The Cleft Palate Program pays according to the suggested Relative Fee Schedule which is now 11 cents per unit. The orthodontists' fees have remain stable for the past four years, with the exception of one slight increase which was issued in 1969. If payment is made by the Cleft Palate Program, the parents are not billed by the physician for the difference between the allowable costs by Child Health Services and the physician's actual charges.
The team personnel are paid directly a consultation fee for the services rendered that day. This is an agreed fee that is paid to the physicians, dentists, and other employment agencies, such as St. Vincent's Hospital for personnel doing the consultation.

C. CLEFT PALATE PROGRAM (Con't'd)

CONFIDENTIAL INFORMATION

On September 15, 1959, the Montana State Board of Health adopted the following regulation (10-002) which is still in effect:

"It shall be the policy of the Montana State Board of Health that all records and information concerning individuals received in the office of the Department of Health, be considered confidential and shall not be divulged by its employees to anyone without the consent of the individual concerned, except as may be required to provide necessary care for the individual or in the protection of the community, and then only shall be divulged to professional persons or public officials who are specifically concerned with the situation. Otherwise, information available to the State Board of Health shall be released only in reports of a statistical or tabular nature."

COOPERATION BETWEEN THE CLEFT PALATE PROGRAM AND OTHER FEDERAL, STATE, LOCAL, AND PRIVATE AGENCIES

Federal Agencies

Indian Health - (Health, Education, and Welfare). Children of Indian descent living on Indian reservations, have medical and dental care provided within the limitations of Indian Health. The Cleft Palate Program authorizes the fees associated with the surgery, if the child is not eligible for benefits from Title XIX, and for orthodontics, Indian Health is generally able to provide general medical care and general dental care. The medical and dental officers at each patient's reservation receive copies of letters and reports, as well as each public health nurse on that reservation.

State Agencies

Social and Rehabilitative Services and local County Welfare Offices-Agreement with Title XIX

Because of the close working relationship between Title XIX and the Cleft Palate Program, there is no written agreement (only verbal) regarding the proper treatment plan for children eligible for both services.

As stated previously, the team evaluations are without charge regardless of the parents income. Children eligible for Title XIX benefits receive the evaluation without charge to Title XIX. The hospitalization and physician costs are paid by Title XIX directly to the hospital and physicians. If the child has been ill and utilized fifteen or more days of the thirty yearly hospitalization days, the Cleft Palate Program will be responsible. The physician costs are still paid for by Title XIX. Title XIX will also pay for general dentistry directly to the dentist. Orthodontics is considered by Title XIX to be of cosmetic in nature and is not covered by Title XIX. Therefore, the Cleft Palate Program will assit with orthodontics.

C. CLEFT PALATE PROGRAM (Cont'd)

The Cleft Palate Program is still able to maintain quality control through the use of certain selected specialists. Title XIX uses these same specialists for treatment of the cleft lip and/or palate.

Department of Institutions - There are children in the following institutions whose care is coordinated by the Program:

The State Training School and Hospital in Boulder for the mentally retarded.
A child at the School for Deaf and Blind in Great Falls. In addition to having a cleft lip and palate, this boy appears to be hard of hearing.

The State Division of Vocational Rehabilitation.- There is no formal written agreement between the Bureau of Maternal and Child Health and the Division of Vocational Rehabilitation. When a child reaches the age of sixteen, a referral is made to the Division of Vocational Rehabilitation. Working together, the two agencies provide the necessary care for the patient's total habilitation. This Agency has always been very helpful to the Cleft Palate Program.

The University of Montana Speech and Hearing Center and the Department of Sociology. The Speech and Hearing Clinic has been helpful in evaluating children who have cleft lips and/or palates, and the sociology department has assisted the Program when there has been a need for follow-up social counseling.

The Montana State University Speech and Hearing Department.- They have all been very helpful to the Cleft Palate Program in providing speech and hearing correction to those who need it.

Local Agencies -
Local County Welfare Departments have assisted in many cases obtaining the necessary social/financial information that is requested for the determination of financial eligibility.

Local County Health Departments have been helpful in providing the follow-up care.

The Lewis & Clark County Children and Youth Project. The Children and Youth Project provides the medical social consultant for the Helena Team for those children who meet the criteria that has been established by the project. The regular clinic services are available to them.

Adoption Agencies -
The Program cooperates with child-placing agencies when they ask for a special evaluation before placing the child in a home. After a child has been placed in an adoptive home, the child remains eligible for all services and benefits offered by the Program as long as the basic eligibility requirements are met.

C. CLEFT PALATE PROGRAM (Cont'd)

Private Agencies -
Shodair Crippled Children's Hospital. This hospital provides the clinic space for the Helena Team in Helena and also provides occasionally some extra diagnostic facilities when the occasion does arise.

St. Vincent's Hospital. - The St. Vincent's Hospital in Billings is contracted on a fee-for-services basis for the medical social consultant. The medical social consultant is also available to provide a regular consultative service to the families when the child is born in St. Vincent's Hospital with a cleft lip and/or palate and when surgery is done in that hospital for children who are on the Program.

The Montana Easter Seal Society does provide speech correction for children in their Centers throughout the State.

The Montana Elks. - The Montana Elks' Mobile Speech and Hearing Program does provide some services for children who have speech difficulties.

Agencies from other states. - Agencies from other states still ask for information about the functioning of the Cleft Palate Program. The Coordinator completed several questionnaires from students at universities and answered severalletters from interested individuals in other states. Most of the information was concerned with program funding and how the Cleft Palate Teams actually functioned.

Professional Association

Many professional associations in the State are considerably interested in the success of the Cleft Palate Program. Following is a list of the associations who are interested and in some ways provide consultation when requested.

The Cleft Palate Association. - The Montana Cleft Palate Association consists of team members and other interested personnel in the State. This Association does not establish policy but they do make suggestions that may eventually become policy. The Cleft Palate Association continues to cooperate with the Cleft Palate Program in bringing into the State guest lecturers each year. This year, Dr. Haskel Gruber, Orthodontist, U.S. Air Force, presented an excellent discussion on orthodontics and the cleft palate child. This was a meeting that was very well accepted by the members of the Association and invited guests.

Montana Medical Association

Montana Dental Association

Montana Speech and Hearing Association

Montana Chapter of Social Workers

Montana Health Association

Montana Nurses Association

SECTION IV. DEMONSTRATION AND SPECIAL PROJECTS

C. CLEFT PALATE PROGRAM (Cont'd)

LENGTH OF CARE

Cleft lip and/or palate habilitation is a long-term program. The treatment is initiated at birth and continues through the patient's growing years. Some surgeries, speech, dental, orthodontic, nutritional, social, and education treatments can be done at a very early age. Other care such as nose revision, orthodontics, and bridge work must wait until the patient is between 19 - 20 years of age. In Montana we serve the patient from birth through 21. Most of the patients are maximally corrected by age 21. Those that are not corrected by the age of 21 are usually followed by Vocational Rehabilitation. A patient remains active on the Cleft Palate Program until one of the following occurs:

Patient no longer desires care through the team. This rarely happens, as most patients want to continue under this Program

Move out of State. When this happens referrals are made to the new place of residence.

Reach maximally corrected. The patient has received all the care the team can provide. This generally happens about age 20.

Reaches age 21. The patient is no longer eligible for financial assistance, but management through the team is still offered to the individual.

SUMMARY AND CONCLUSION

The financial difficulties experienced by the Cleft Palate Program are no different than those experienced in other federal, state, and local programs where the appropriations must need to remain consistent where the cost for delivering services are continually increasing. The administrators of the program must continue to find additional revenue and better ways to maximally utilize the funds that are not available. This was, in part, accomplished when the State Legislature did appropriate $10,000 to be utilized by the Program, as the Program is a great service to the children born with clefts. It is felt by the Legislature that this is a good expenditure for tax revenue.

Some of the clients who have been enrolled on the Program for many years and have utilized considerable amount of funds are taking meaningful places in society. Several of the clients have received Doctorate Degrees in various areas of learning. Some of the patients are in the nursing profession. Some of the individuals are educators, and some are making a career of the Armed Forces. It is our opinion that this Program has helped to insure that children born with cleft lips and/or palates have more equality and opportunity to develop and progress than they would have had if they had not been able to receive the benefits of the long-range planning program. The Program proposes to continue to be a source of information about the problems of clefts and care, and at the same time, to be the finest in up-to-date service to children with clefts.

COST FOR PROGRAM

Attached in the appendix are Tables 1 - 4 which show the costs of the Program for five major categories. It must be stressed that these tables how cost to the Program, not the actual cost, as we don't know the costs of those services which private health insurance paid. The dentistry and orthodontic categories are, however, actual costs for the services provided as no health insurance participated with dental care or orthodontic costs during the four years listed on the tables.

It is noticeable that more and more services are being paid for by insurance. This is the major reason the costs have been kept as low as they are at this time.

ASSURANCES

This project does comply with the regulations, policies, guidelines, and requirements including OMB Circulars Nos. A-87, A-95, and A-102, as they relate to the applications, acceptance and use of Federal funds for this Federally assisted project.

SECTION IV. DEMONSTRATION AND SPECIAL PROJECTS

D. Early and Periodic Screening, Diagnosis and Treatment Program

1. Program Background

a. Funding Source - The Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) is a recent addition to Title XIX of the Social Security Act. It calls for early casefinding and screening of health problems among children (under 21 years of age) eligible for medical assistance under the Title XIX State plan. It also calls for providing for the necessary health care (if the recipient so chooses, within 60 days of screening) to correct the identified problems. The Medicaid program funds the screening operation, reimburses physicians for diagnosis and all medical professionals for treatment eligible under the State plan.

b. Regulatory Foundation - The EPSDT Program is federally funded and established as a required element of the Medicaid Program. A penalty of a one percent reduction of federal assistance towards the Aid for Families with Dependent Children (AFDC) Program is to be imposed for failure to have an EPSDT Program. The pertinent sections of the Code of Federal Regulations are: 45CFR 249.10 (a)(3) and (b)(4)(ii).

The regulations require coordination with Title V agencies and allow for contracting for screening services with responsible health agencies. In Montana, the Social and Rehabilitation Services Department, Medical Assistance Bureau (the Title XIX single state agency) has contracted with the Department of Health and Environmental Sciences, Maternal and Child Health Bureau (primarily responsible for Title V) to do the screening and referral portion of EPSDT. Private physicians may also contract to provide screening services.

c. Need for Program - For the first time in Medicaid history, EPSDT regulations direct the state programs to promote preventive health. The value of preventive health and early casefinding is both human and financial.

-- When a health problem can be prevented, the individual avoids both suffering and the debility which would have occurred before diagnosis.

-- When a disease or condition is diagnosed early, the individual may avoid the permanent disability or death which follows its onset.

-- When an individual can be assured that he is healthy, he avoids any anxiety he may have about his condition.

-- Further, by emphasizing preventive health, EPSDT can reduce the necessity for institutional care that consumes so much of the money available for health services.

d. Current Status - The program has been in operation in Montana for three full years (the first screening clinic was conducted in Park County in

October 1972). It is just entering its third screening cycle. Screening involves all Montana counties either through subcontracts with six county health departments or through state teams circuiting multiple sites in the remaining fifty counties.

Screening clinics are conducted by the State teams at least once a year for each county covered. Subcontracting county health departments have clinics at least every two months. Requests for screening must be satisfied within 60 days. Transportation, day care or other social services are offered by the county welfare office to facilitate an individual's obtaining screening or medical services. Such requests are satisfied even if a county clinic is not to be scheduled within sixty days by referring the recipient to a nearby county health department, setting up an appointment with a local doctor or sidetracking a State team enroute to or from another scheduled county clinic.

2. Program Goals and Objectives

a. Program Goals - The EPSDT Program fits within the Maternal and Child Health Bureau's general goals of improving family and childhood health in Montana. More narrowly, the program's goals are:

(1) to achieve a better health standard through periodic screening of children's health conditions,

(2) to promote preventive health,

(3) to search out eligible children, inform them of the program and encourage them to participate in it, and

(4) to arrange and provide for periodic screening, referral, diagnosis and treatment services as a systematic package.

b. Operational Objectives - To achieve the goals the program supports systemwide health delivery mechanisms. The program has five objectives that define delivery system approaches:

(1) To increase the number of subcontract counties performing full EPSDT services,

(2) To establish subcontract counties performing partial EPSDT services with some professional support from the State,

(3) To continue to provide complete EPSDT services through clinics conducted by State teams to the remaining counties,

(4) To establish formal agreements or mechanisms for information exchange and EPSDT service coordination with services such as Head Start, Indian Health Service and WIC, and

(5) To provide health educational opportunities as a part of screening services.

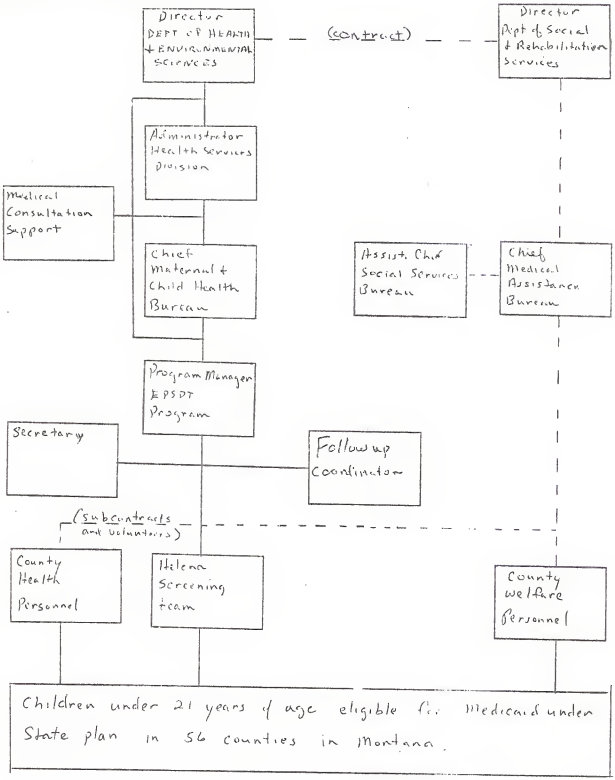
3. Program Organization

The organizational structure for the program is presented in Exhibit 1 on the following page. It indicates the contract relationship

EXHIBIT I

EPSDT ORGANIZATIONAL CHART

SECTION IV. D. (continued)



between the Department of Health and Environmental Sciences (DHES) and the Department of Social and Rehabilitation Services (SRS). SRS pays DHES to conduct the screening and related services in behalf of the State's Medicaid program. The contract is renegotiated annually. Payments are reimbursement of actual costs incurred each quarter.

The main liaison for SRS is the Chief of the Medical Assistance Bureau, who establishes state policy interpretation for the program, negotiates the annual budget, approves quarterly contract payments to DHES. The Assistant Chief of the Social Services Bureau facilitates coordination between county welfare offices and the health screening teams or county health departments when needed.

The Program Manager for the EPSDT Program works under the immediate direction of the Chief of the Maternal and Child Health Services Bureau who in turn operates the Bureau under the general direction of the Administrator of the Health Services Division.

A variety of medical consultation is available to the program within the Bureau itself, at the Division level, and in other divisions of the Department. From the Nursing Bureau in the Central Services Division, nursing consultation and advice on county Community Health Nurse capacities are available. The Epidemiologist, a pediatrician, in the Preventive Health Bureau, a part of the Health Services Division, is the program's medical advisor. Also available in the MCH Bureau is that Bureau's nursing consultant who serves as the program's nursing coordinator at the direction of the Bureau Chief. Medical consultation through SRS is also available.

The Program Manager is responsible for implementing EPSDT services as called for in the contract with SRS. This includes directing available resources to achieve program objectives and maintaining quality screening standards as established through medical consultation and Department policy. Negotiating the terms and budget of the general contract with SRS and the subcontracts with qualified county health departments is also the Program Manager's responsibility.

The program has one secretary and one followup coordinator who work under the general direction of the Program Manager. The secretary is located in the Helena office on a full-time basis and provides secretarial support for both the overall administration of the program and the screening team. The secretary also provides some secretarial service to the Maternal Child Health Services Bureau.

The followup coordinator is a registered nurse who currently fills this position on a half-time basis. The primary responsibility of this position is to maintain all programmatic data generated by each screening and to coordinate followup activities (i.e., tracking screening results). Another responsibility is to organize programmatic data in a manner convenient for regular analysis and to assist the Program Manager in the analysis of that data for evaluative purposes. A secondary role is to serve as a backup screening nurse in the case of illness or conflicting vacation schedules on the part of regular screening team members.

Screening and followup activities for eligible children in Montana's 56 counties are provided through a mix of the following service delivery groups:

(1) State supervised health screening team,
(2) County public health personnel (if available), and
(3) County welfare personnel.

In counties other than full-service subcontract counties, the actual screening process is carried out by a team of nurses with mobile units. The team is stationed in Helena and screens the entire state not serviced through county subcontracts. The team consists of three nurses. All have been specially trained in the physical assessment skills. As noted below the State health screening team is augmented by both professional and lay personnel.

County public health personnel (usually Community Health Nurses) are involved in the program either through subcontracts between the State DHES and the county board of health or through "volunteering" professional services for a particular screening. The subcontracts are with qualified counties capable of providing full screening, follow-up and reporting services independent of State supervised health screening team members. The State DHES reimburses subcontracting counties quarterly at a rate of $13 per followed-up screening.

The counties currently under contract for providing full EPSDT services are:

-- Cascade
-- Flathead
-- Missoula
-- Silver Bow
-- Yellowstone

Lewis and Clark County is under contract to provide full EPSDT services to children under thirteen years of age (to coincide with Children and Youth Project services being provided in that county). Children thirteen and older are being serviced by a State supervised health screening team.

Other qualified counties have shown interest in subcontracting to provide this service. It is a matter of MCH Bureau policy to encourage such contracts. One additional contract is being considered at this time. This is with Gallatin County. Other counties may be added to the list of subcontracting counties as public health personnel express interest and the opportunity for training is available.

All counties not under subcontract are serviced primarily by health screening team members with public health personnel working in a "volunteer" capacity. Often other qualified health professionals (usually nurses) residing in the community volunteer their services as well. No reimbursement for either organizational activities or professional services are made in these counties.

Under consideration at this time is the possibility of an "intermediate" (vs. full-service) subcontract with counties which can undertake most activities associated with the preparation for the screening, conduct of the screening itself, followup and record keeping. However, they may not have the local professional help needed to conduct a thorough assessment and require State supervised health screening team members to augment their local capabilities. Such a contract would reimburse the county for EPSDT services actually provided (something less than the $13 per child provided for full-service counties) and state the

level of State team on-site capability required to provide the desired service.

County welfare personnel have the primary role for the casefinding phase of the EPSDT program. This involves the identification of eligible Title XIX children interested in being availed screening services and arranging for their being scheduled into a screening site. Notification of eligibles occurs during eligibility determination and redetermination. County welfare also helps organize volunteers as may be necessary in cooperation with public health personnel.

Typically, county welfare will obtain volunteers who can undertake screening roles that do not require professional medical judgment (e.g., registration, urinalysis and height/weight measurement). Public health personnel usually arrange for volunteers who may need to employ trained professional medical judgment in the conduct of the screening (e.g., hearing tests, blood pressure readings, Denver Developmental Screening Test, vision tests, hematocrit and other physical assessments).

County welfare personnel (usually social service workers) also participate in the screening itself by providing, during the pre-screening conference, needed insights into the sociological circumstances surrounding each scheduled child, and during the post-screening conference by identifying the best procedures to support the effort to get referred children to required medical services.

Both county welfare and county public health personnel work cooperatively to ensure reasonably that referred children get to the indicated medical service. The post-screening conference is used to sort out who will undertake which efforts that may be required to encourage the families of referred children to avail themselves of the indicated medical service. In all cases, the welfare department makes social services such as transportation and day care available to help ensure appropriate response to referrals.

4. Interagency Cooperation

a. SRS/DHES Contract - As explained in Part 3 above, the EPSDT program in Montana is primarily implemented through a contract between SRS and DHES which establishes the single most important aspect of interagency cooperation: i.e., the combined efforts of the social services and health delivery systems.

b. County Health Departments - An outgrowth of the general SRS/DHES contract is the subcontracts with full-service counties for the conduct of EPSDT services. As noted in Part 3 above there are six such subcontracts. Other full-service subcontracts are in the offing and the possibility of intermediate partial-service subcontracts is being considered. An eventual goal of these various subcontract relationships is to strengthen county level public health service and to foster more extensive health delivery roles at the county level rather than at the State level.

c. Title V and Related Programs - The SRS/DHES general contract establishes the cooperative basis for the EPSDT Program with Title V Programs (e.g., Maternal and Infant Care, Children and Youth, Crippled Children's Services) since DHES's lead agency (the MCH Bureau) for EPSDT has the responsibility for administering such activities. However,

SECTION IV. D. (continued)
clarifying intradepartmental agreements are not entirely in place and require further examination to avoid duplication of screening and/or data gathering efforts.

d. Other Public Health Related Programs - In different communities a varying mix of health services involving screening type activities may be available over and above those being provided under the auspices of DHES. These can include school health programs, Indian Health Services, Easter Seal clinics and Head Start programs. Further effort to identify the regularity and screening activity of these programs is needed and then to develop agreements that eliminate duplication of effort and coordinate joint data needs or capacities.

5. EPSDT Process

The EPSDT process is described graphically in Exhibit II on the next page. The following narrative keys into the numbers on the chart and explains the process. The process divides into five phases:

A.	Casefinding	(1 through 4)
B.	Site preparation	(1, 5 and 6)
C.	Screening	(7 through 11)
D.	Followup	(12 through 16)
E.	Reporting	(17 and 21)

a. Casefinding - Casefinding and site preparation are generally simultaneous activities both beginning a few months prior to actual screening when the State health screening team negotiates a screening date with the county welfare office (1). This year, in an attempt to accommodate the needs of the counties, county welfare personnel were asked to list preferred times for screening. Based on these preferences, the State health teams have scheduled their detailed agendas.

Once the screening date has been negotiated and logistics discussed over the phone, the health screening team summarizes the conversation in a letter of confirmation which includes special instructions concerning scheduling, facility arrangements and volunteer help as appropriate. Enclosed with the letter are history/consent forms that will be sent to the parents or guardian of eligible recipients.

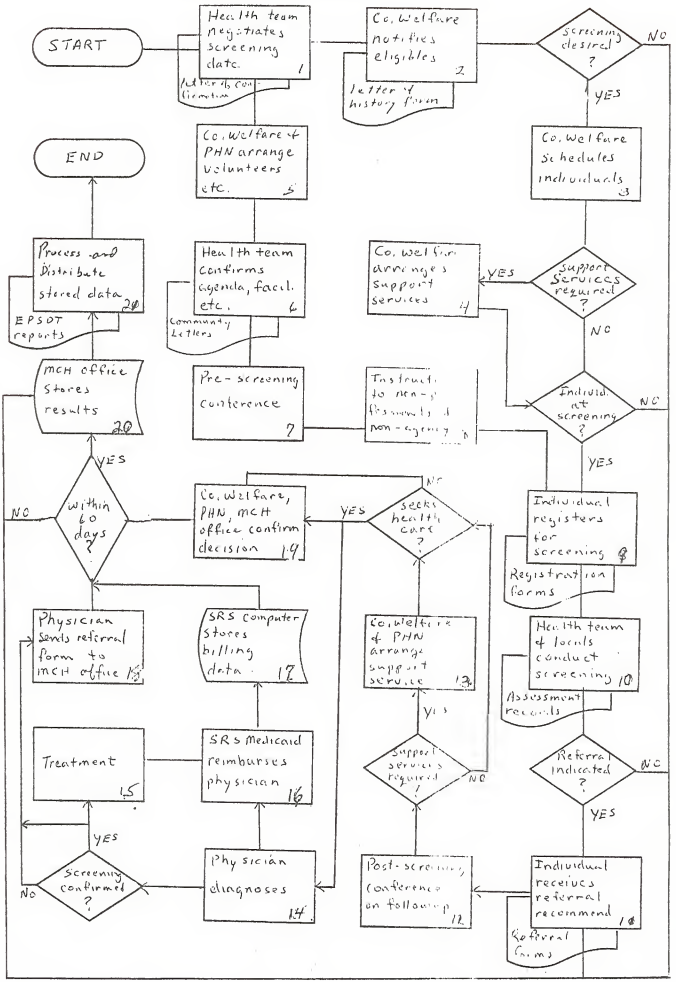
Subcontract counties, due to the relatively large Title XIX caseloads, have set up screening opportunities at least every two months. In this way, there needn't be a heavy screening influx at any one time during the year. This frequent schedule is made known to the county welfare office affected and referrals thereby accommodated and the ability to respond to requests within 60 days facilitated.

As the scheduled screening date approaches (about two weeks prior) county welfare personnel notify families with Title XIX eligible individuals that screening is coming up (2) and request them to fill out a medical history form with signed consent to conduct the screening in behalf of the individual. If the screening is to be the recipient's first under the program, the form is white. If it is to be a repeat screening, the form and pink and includes a slight rephrasing to reflect the prior screening. A return of the signed history form indicates that the family desires the screening.

SECTION IV. D. (continued)

EXHIBIT II

EPSDT PROCESS



SECTION IV. D. (continued)

In some instances a family may wait to fill out the form until the day of registration.

Within a few days before the scheduled screening, county welfare personnel schedule the families and individuals who have expressed interest in the screening for specific times (3). The State health team has provided the county welfare office with instructions that indicate the preferred scheduling arrangement and workload.

As part of the scheduling effort, county welfare personnel determine whether support services are required to get the family or individual to the screening site. If so, county welfare arranges the appropriate services (4), usually transportation. Whether the family or individual require support services or not, the opportunity to avail onself of screening services is a personal choice. If the intended recipients show up at the screening site and have a consent-history form signed by a parent or legal guardian, then the registration for screening (8) may begin. Those scheduled for screening who do not show up as scheduled are recontacted to confirm whether or not they wish screening services and whether another appointment or some assistance such as transportation may help them obtain the screening service.

b. Site Preparation - As noted for casefinding, site preparation activities begin when the State health screening team negotiates a screening date with the county welfare office (1). Of course, subcontract counties once established have regularized times and places for screening that do not necessarily require repeated notification on site arrangements.

Site preparation activities are conducted more or less concurrently with casefinding activities. County welfare personnel and the community health nurse work cooperatively to arrange for volunteers to help with the screening effort (5). Typically, county welfare will obtain volunteers who can undertake screening roles that do not require professional medical judgment:

-- registration,
-- urinalysis, and
-- height/weight measurements.

Public health personnel usually arrange for volunteers who may need to employ trained professional medical judgment in the conduct of the screening:

-- hearing tests,
-- blood pressure readings,
-- Denver Developmental Screening Test,
-- vision test,
-- hematocrit, and
-- other physical assessments.

When the typical two-member State health screening team is used to conduct the screening, volunteer requirements include three non-professionals and two to three professionals (depending on the size of the scheduled caseload). Full-service subcontract counties are typically staffed to handle screening without volunteers or State health screening team members. The proposed "intermediate" subcontract counties may use a mix of professional resources:

- -- Combined county public health personnel and State team members,
- -- Combined county public health personnel and "contract" local professional health personnel,
- -- Combined county local public health personnel and volunteer local professional health personnel, and
- -- A combination of the above patterns.

During the two weeks before the scheduled screening, health screening team members call both the county welfare personnel and public health personnel to confirm the agenda, volunteer availability and facility arrangements (6). During this phase particulars about scheduling are negotiated to insure appropriate distribution of children according to the number of professional and non-professional volunteers that are available and to insure adequate time has been allowed for the pre-screening conference (7) and the post-screening conference (11).

Other preparatory activities include:

- -- notification of local physicians and dentists by letter that screening is scheduled,
- -- notification of local school administrators that screening is scheduled,
- -- identification of area specialists likely to be used as referral resources,
- -- identification of special facilities and clinics that may be used to augment screening activities or with which screening agendas should be coordinated, and
- -- coordinating team travel and lodging arrangements.

c. Screening - Screening is initiated by a pre-screening conference (7) conducted during the hour or so before families and individuals are scheduled to register for screening (8) and after screening equipment has been unloaded and set up in the screening facility. Attending the conference are:

- -- State health screening team members,
- -- County social worker,
- -- County community health nurse (if available), and
- -- paraprofessionals responsible to either county welfare or county health (e.g., homemakers).

The purposes of the pre-screening conference are to:

- -- establish rapport among professionals and paraprofessionals who will be conducting the screening,
- -- identify screening activities and personnel who will administer them,
- -- review the scheduled screening caseload to identify the social and environmental context of the family and individuals expected to be serviced, and
- -- identify and implement any last minute arrangements that may be needed to aid families and individuals in getting to the screening site.

In the case of subcontract counties, the pre-screening conference may be handled less formally through periodic visits or phone communication as screening events are scheduled.

If the pre-screening conference is handled with these purposes in mind, the percent of scheduled individuals attending screening, the quality of screening and the successful implementation of followup activities should all be enhanced.

Just before individuals arrive for screening, non-professionals and non-agency professionals are given specific instructions concerning each screening station that will be manned by them (8). Of particular importance are the instructions to the registrar since many decisions and form selections are required at this station that may be confusing to a newcomer.

Once all participants have received instruction and the scheduled children begin arriving, registration (9) and screening (10) proceed. At registration names and other identification labels are placed on the following forms as appropriate to age:

-- EPSDT History Form
-- EPSDT Interim History Form
-- Screening Examination Form
-- Denver Developmental Screening Test
-- Record Form for Titmus Tester
-- Immunization Permit
-- Growth Curve Charts for Infant Boys
Boys
Infant Girls
Girls

Once registration is completed, the children proceed through the screening stations (10) during which appropriate entries on the forms noted above are made.

The final screening station is the assessment station at which final examinations are made, results of prior tests as recorded on the above forms are considered and a determination whether evidence warrants referring the child for specific diagnoses. If such a referral is not indicated, that fact is included in the program data base (20) for that county.

If a referral is indicated, the parents and/or individual receives referral recommendations from the assessing nurse (11). The specific recommendations are recorded on a two-part form concerning three categories of referral:

-- referrals for physical cause,
-- referrals for dental cause,
-- referrals to other disciplines.

One part of the form is a returnable prepaid postcard which the diagnosing physician mails (18) upon completing his diagnosis (14). This is done whether or not the screening assessment is confirmed. Ultimately this card becomes a part of the program data base (20). The other part of the form is brief instructions concerning the nature of the referral. Specific records concerning measurements and assessment of the individual are maintained by the screening team and also become a part of the program data base (20).

d. Followup - When all scheduled individuals have been screened, a post-screening conference on followup is held (12). The same people who participated in the pre-screening conference are part of this event. The purposes of the post-screening conference are to:

-- review all cases involving a referral so that all professionals may understand the reason and nature of the referral,
-- identify support services that may be required to aid a referred individual in an effort to obtain medical service,
-- designate lead roles in following up referrals for each case and the appropriate time of such followup (i.e., cases with acute symptoms may be followed up immediately, whereas less urgent referrals may allow for a 20-30 day time lapse to allow time for individual action on the referral. In all cases, a 60-day period is allowed for identification of successful followup).
-- inform the county social worker and community health nurse about the timing of information feedback on referrals (i.e., within 5 to 7 days following the screening, both will receive a composite list concerning all referrals by type against which a check off of completed referral card returns may be made. The MCH Bureau will begin phoning that information to both parties as the initial returns are received, usually between 20 and 30 days following screening. Subsequent returns will also be phoned until the 60-day time allowance is reached.)

If the post-screening conference is handled with these purposes in mind, the successful implementation of followup activities should be enhanced. It should be noted that although it is desirable to conduct the post-screening conference in joint session immediately following screening, late screening schedules and tight travel schedules may preclude the opportunity. In such circumstances the conference will be conducted by phone from the MCH Bureau office after the social worker and community health nurse have received the composite referral list.

Screening team referrals are recommendations only. The discussion of the referral with the individual includes the identification of known medical services in the area. Families and individuals are free to decide whether or not to act on the recommendations and if they do act, to utilize the medical practitioner of their choice. If it is determined that certain support services such as transportation may help a recipient act on a referral, the county social worker or community health nurse will help arrange for the service (13).

Whether or not the recipient seeks the appropriate health care, the county welfare office or community health nurse attempt to confirm the decision (19) which is ultimately recorded in the program data base (20). Such confirmation is typically by personal contact and is a procedure that assures that the recipient does not neglect the referral due to misunderstanding or oversight.

If the recipient does seek health care, the next step will be to visit a physician, dentist or other professional discipline for diagnosis (14) and possible subsequent treatment (15) if the screening

assessment is confirmed. For diagnosis and/or treatment, the physician is reimbursed for services rendered by the SRS Medicaid program (1). The fact that the medical services are no cost to the recipient removes a major obstacle in the effort to get cases taken care of early before conditions become acute, debilitating and expensive.

e. Reporting - The casefinding, screening and followup phases of the EPSDT process described above each provide information that contributes to the overall reporting framework of the program. The Maternal and Child Health Services Bureau maintains a central record keeping operation that stores all information resulting from the screening process (20). Periodically this information is processed into varying report formats and distributed (21).

Exhibit III on the next page expands the report processing and distribution activity (Exhibit II - 21) to more clearly explain the steps involved. The off-page indicators reference data sources noted in Exhibit II.

Information resulting from screening (10) and referrals (11) is entered on a composite list (A) soon after the screening is conducted. In subcontract counties, staff there fill in the list, retain a copy and mail one to the MCH Bureau for documentation of followup and further processing. In other counties, the MCH Bureau completes the form from case files.

The composite list is used for coding screening and followup data for eventual computer processing (C). The form is also useful for certain manually operated followup activities (B). Since followup activities are coordinated and documented at the MCH Bureau, all followup entries on the composite list are made by that Bureau's staff.

The composite list as completed just after screening is distributed to the county community health nurse and social worker (D) to aid them in their followup activities. If the county health department is subcontracting for screening, it simply retains a copy of the form for itself and delivers a copy to the social worker.

Other recipients of the composite list after screening are the SRS administration (E) and the SRS data processing center (F) which enters the data on its computer system and generates its regular monthly reports and federal reports (G) as required.

Within sixty days of screening, all efforts to document recipient action on referrals must be completed. MCH Bureau staff in the EPSDT office document (B) such action through three sources:

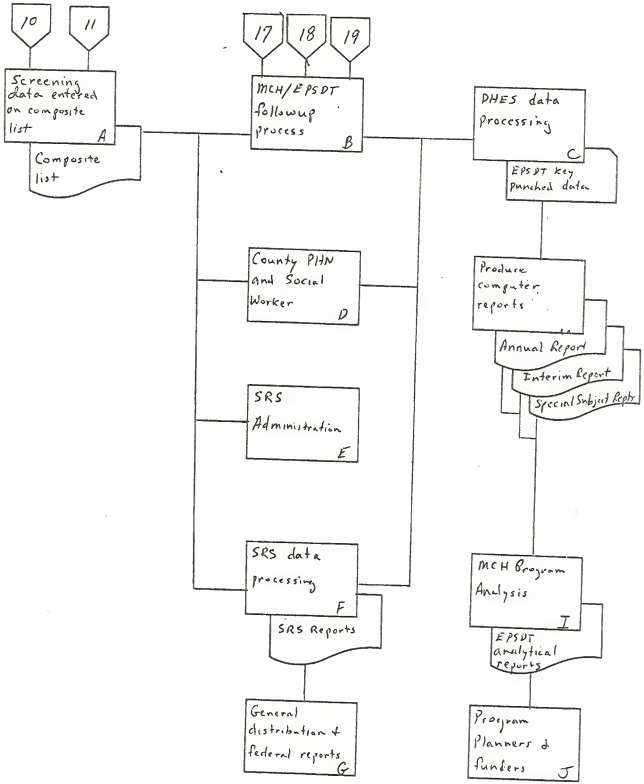
-- The SRS computerized vendor billing system (17) in which the doctor's invoice for rendering diagnostic or treatment services are stored,

-- The mail return of a doctor's confirmation of rendering service (18), and

-- The community health nurse's or welfare worker's personal confirmation of an appointment made, medical visit made, or rejection of service (19).

EXHIBIT III

EPSDT Report Processing and Distribution



SECTION IV. D. (continued)

Coded entries concerning the status of followup are made on the composite form throughout the sixty-day period. Since considerable phone communication about followup occurs between the MCH Bureau and the county offices during this time, county personnel may also be coding followup status on their copies of the composite forms for reference purposes (P). However, the MCH Bureau's copy serves as formal input to the DHES (C) and the SRS (F) data processing systems. All confirming documentation except mail return of the doctor's services (18) will remain at the county level.

Once all data is encoded on the composite form, the forms are delivered to the Bureau of Records and Statistics for key punching on computer cards (C). The Department of Administration's computer center then produces computer reports (H) from this data according to programs designed by DHES staff.

The basic report is the annual report which displays data by county and by referred condition for screenings conducted statewide during the annual period. If composite lists are processed monthly, interim reports may be available for selected screenings completed during the annual period. This is not currently systematized. For any data stored on tape, special subject reports may be generated according to need. Such reports may concern specified conditions for selected areas of the state or for certain recipient characteristics.

The computer reports then provide input to MCH Bureau program analysis efforts (I) which result in analytical narrative reports that may guide program planners and funders (J) in their decision-making processes.

SECTION IV. DEMONSTRATION AND SPECIAL PROJECTS

E. WIC

1. Introduction

Montana, as a rural state, has unique problems with only two statistical metropolitan areas in the state. The total population of Montana is 735,000. There is an inadequate quantity of medical services and a maldistribution of those services typical to a rural state.

The ten counties and our seven reservations were selected for the Women, Infants and Children (WIC) Program based on the following economic, social and financial criteria.

a. Projects encompass areas of grestest population density.

b. Projects encompass areas of highest per capita income correlated with employment centers, areas also most devastatingly affected by Montana's unemployment rate, for February, 1975, of 10 percent as compared to the national average of 9.1 percent.

c. Pertinent health related statistics were also considered.

Four and one-half percent ($4\frac{1}{2}\%$) of Montanans in 1972 did not receive prenatal care until the third trimester. The teen years are especially a high risk period for pregnancy. Twenty-one and one-half percent ($21\frac{1}{2}\%$) of the women pregnant under 15 years of age did not receive health care until the third trimester of pregnancy. A good outcome of pregnancy is directly correlated with early involvement in prenatal care.

The WIC program in Montana is a health as well as a nutritional program. WIC participants are obligated to make a commitment to on-going preventive health care from their local health agency, Indian Health Services or from a private physician, i.e., well-child clinics, prenatal classes, prenatal care, immunization schedules, venereal disease programs, family planning, and early periodic diagnostic treatment programs, etc. Thus, with WIC, we will be providing a method of improving eligible persons' nutrition and with the distribution of foods, an incentive to obtain on-going preventive health care.

The following health statistics were criteria used in determination of WIC project locations, and these were also

E. WIC (Con't)

1. Introduction (Con't)

used in the development of impact evaluation studies. Statistics considered were the incidence of low birth weight infants, incidence of infant, prenatal, neonatal mortality rates, reported incidence of malnutrition and iron deficiency anemia.

Our principal aim through WIC is to provide nutritious supplemental foods to high risk, low income women, infants and children using these foods not only as a means of elevating their nutritional status, which in itself will improve health, but also using the foods as an incentive to get their families into on-going preventive health care, to improve pregnancy outcome, physical and mental development of the infants and children involved.

We plan to develop medical impact evaluation studies which will demonstrate the value of a food distribution program so that similar programs will be likely to be implemented and funded.

We plan, through WIC, to improve Montana's economy by providing new jobs related to WIC and by administering a program that will enable an additional $3.1 million in federal monies to flow into our economy.

Our specific goals, objectives and results expected are as follows.

2. Program

Through WIC, we plan to achieve the following:

a. To improve the health and nutrition of low income Montana families, specifically pregnant women, nursing mothers and infants and children to four years of age. Through continuation of the WIC program, Montana vital statistics for fiscal year 1978 will not exceed the United States statistics for that same year in the following areas. Counties will show a decrease in:

---Incidence of low birth weight infants.

---Incidence of neonatal, postnatal and infant mortality.

---Incidence of infant morbidity.

E. WIC (Con't)

2. Program (Con't)

---Incidence of reported cases of malnutrition and iron deficiency anemia.

b. To increase the use of available preventive health care services by low income Montana families, specifically women, infants and children to four years of age by at least 20 percent from the previous fiscal year 1975 totals.

---An increase in the number of well-child visits as noted in clinic records.

---An increase in the number of prenatal visits as noted in clinic records.

---An increase in the number of mothers getting prenatal care in the first trimester of pregnancy.

c. To improve Montana's economy.

---An increase by 28 the number of full-time jobs for Montanans.

---To allow for the flow of $3.1 million necessary for WIC program operations into our economy.

---To increase the spending power of WIC recipients' finances by providing them with highly nutritious food supplements and preventive health care so they will not have to pay for these goods and services out of their limited incomes.

3. Administrative

We plan to achieve the WIC program goals and objectives through effective program administration. The administrative goals and objectives are:

a. To instigate appropriate administrative procedures that will enable the statewide WIC program to function in an organized manner with plans and decisions based on well-defined written objectives, policies and procedures.

---The management-by-objective approach will be implemented and followed relative to the health impact evaluation studies and to state and local program operation.

SECTION IV. DEMONSTRATION AND SPECIAL PROJECTS (Con't)

E. WIC (Con't)

3. Administrative (Con't)

---The management-by-objective strategy will be submitted to the U. S. Department of Agriculture by July 1, 1976, and will address the following:

Administrative cost per patient.
Medical impact evaluations.
Administrative procedural design.

---Federal regulations and guidelines will be used as policy until more definitive state policy is developed. There will be on-going evaluation of federal regulations and state policy in relationship to the final benefit of the program to the recipient.

4. Evaluation

Medical impact evaluation studies will be designed to demonstrate the effect of WIC intervention upon statistics (taken from EPSDT, Vital Statistics and the Dikewood Corporation, who process Blue Cross claims and Blue Shield claims) of health related problems peculiar to our state and to the individual counties having WIC.

a. To development of medical impact evaluation study for the entire state based on present statistics demonstrating health-related problems that are existing in our state (see program goals).

b. To develop medical impact evaluation studies for the individual WIC projects based on present statistics demonstrating particular health-related problems specific to each project area.

5. Approach

a. The management plan describes administrative procedures involving the flow of U. S. Department of Agriculture money through the state and local systems to the recipient and also shows the daily computerized reconciliation process between the bank and the State Department of Health and Environmental Sciences accounting section. The method described has proven to be highly workable, efficient and provides good fiscal control at both local and state levels.

SECTION IV. DEMONSTRATION AND SPECIAL PROJECTS (Con't)

E. WIC (Con't)

5. Approach (Con't)

b. Previously U. S. Department of Agriculture approved caseloads to be reached by July 1, 1975, and to be maintained during fiscal year 1976 are used.

c. The statistical data to be collected and maintained for WIC evaluation purposes is summarized and computerized annually by the Department of Health and Environmental Sciences Records and Statistics Bureau.

WIC medical data required locally for evaluation includes the following:

---Pregnant Women
Outcome of pregnancy
Gestational age
Birth weight
---Infants and Children
Initially and every six months
Height
Weight
Hematocrit and hemoglobin
Head circumference (under age two)
---Other
Medical and social data as required for a specific county based on the impact evaluation study designed for the particular county.

d. Many different organization coopérators, consultants and other key individuals will be assisting both the Department of Health and Environmental Sciences Maternal and Child Health Bureau and the local projects in implementing the WIC program. Individuals who have already made a commitment for involvement during fiscal year 1976 include:

---Wholesale Infant Formula Companies
Provide grocer education
Provide program materials for
Nutrition education
Medical evaluation/growth grids, tape measuring
Program promotion
Displays/formula samples
---County Extension Agents and EFNEP Agents
Assist in community organization
program promotion
Nutrition education (time and materials) in limited number of counties
Referrals

E. WIC (Con't)

5. Approach (Con't)

---State Department of Health and Environmental Sciences
Centralized Services
Development of continued assistance in the management system
---Welfare Departments (state and county)
Provides project site space and office equipment in limited number of counties
Referrals in all communities
Positive outreach
---Early and Periodic Screening Diagnosis and Treatment Program (EPSDT)
Followup on health care component
Sharing of health intake data, both general health statistics and patient specific data, i.e., HCT's, HT, and WTS
Referrals
---Montana Food Distributors
Monthly suggested retail price lists for all specific eligible foods
Grocer education
---County Health Departments - Provide to counties:
Space, personnel, clinic and office equipment and supplies administration
---Indian Health Services - Provide to reservations:
Health services, well-child clinics, prenatal clinics, rental, telephone, supplies (clinical and office equipment)
---Headstart, 4 C's welfare offices, county extension, physicians, family planning clinics, hospitals, school and public health nurses all given invaluable assistance in outreach and referral to the program.
---March of Dimes
Centrifuge and hematocrit supplies to at least one county

6. Financial Eligibility

WIC eligibility in terms of financial status is defined as:

a. County Recipients

Persons eligible for free or reduced medical care are eligible for WIC. The standard used by the family planning clinics, "Persons with incomes up to 150 percent OEO proverty guidelines shall be eligible for free or reduced medical care," is used for WIC.

E. WIC (Con't)

6. Financial Eligibility (Con't)

b. Indian Reservation Recipients

All native American persons or persons married to native Americans are eligible for Indian Health Services at no cost and if in the target population are eligible for the WIC program.

Success of existing WIC projects is quite evident. On the two Indian reservations where pilot WIC programs had been underway, visits to well-child clinics increased by 132.6 percent on the Fort Peck Reservation and by 164.3 percent on the Northern Cheyenne Reservation during the first six months of operation. These figures compare to an increase of only 15.2 percent in well-child visits in the same six months on a reservation without a WIC program.

Data is being collected for the medical impact evaluation studies, but valid results as to the health impact of WIC cannot be yet determined as a sufficient length of time has not yet passed since program start up.

SECTION V. PROGRAM OF PROJECTS

SECTION V. PROGRAM OF PROJECTS

A. MATERNITY AND INFANT CARE PROJECT

I. BACKGROUND

With Federal legislation requiring that each state must have at least one maternity and infant care project, Yellowstone County was considered to be one of the possible sites because Yellowstone County did not have an organized community health services with emphasis on county-wide Maternal and Child Health Care. The State Department of Health and Environmental Sciences, Maternal and Child Health Bureau has sponsored a maternal child nursing program within the city of Billings for about ten years. The information collected from the records of the patients served in this project suggested the need for a geographical area in the south Billings tract. Yellowstone County covers an area of 2,666 square miles and is located in the South Central region of Montana. According to the 1974 census estimates there is a population of 96,865 people residing within the county boundaries. There is an average residence of 36.3 persons per square mile. Billings is the county's largest city with an estimated population of 68,276 residing within the city limits. Within the metropolitian area of Billings, the estimated population is 82,985.

95.91% of Yellowstone County's population is white, 2.26% is of Mexican-American decent, 1.22% are of Indian decent, .26% Black, and .35% other. Approximately 46% of the minority population has an income less than the poverty level. State-wide the percentage is 39.7% of the minority population with an income lower than poverty level. Yellowstone County has 16.04% of the population falling below 125% of poverty level as compared to 19.1% of the total state-wide population falling below 125% of poverty level. Further examination reveals that there are two male heads of household with incomes

falling below 125% of poverty level for every female head of a household falling within the same income level.

The State of Montana has 2% of the population receiving medical assistance through Social and Rehabilatative Services. Within Yellowstone County there is the same ratio (2%) of the residents receiving medical assistance from Social nad REhabilitative Services.

Vital Statistics information reports there were 1,092 infants born to Billings city residents, while 862 infants were born to mothers who did not reside within the city limits. During calendar year 1974, there were 291 infants born to teenage mothers in Yellowstone County. 224 infants were born to mothers whose residence was within Yellowstone County boundaries. 149 infants were born to mothers whose residence was within the city of Billings limits. Teenage mothers who resided within Laurel city limits delivered ten infants. There were 65 infants born to teenage mothers whose residence was in the county, but not in Billings' or Laurel's city limits.

The following physicians provide medical care to children, infants, and pregnant women within Yellowstone County. The majority of these physicians' offices are located within Billings city limits. There are eight pediatricians and four general practitioners in Billings who offer services to infants and children. There are six obstetricians whose offices are in Billings and provide OB-GYN services to women. Two general practitioners whose offices are located in Billings occasionally deliver infants. There is one general practitioner whose office is located in Laurel and occasionally deliver infants. Laurel also has two general practitioners who provide services for infants and children.

The two major hospitals located in Billings and serving Yellowstone County, recently consolidated maternity care programs in order to provide better quality care. The maternity and nursery facilities are now located at ST. Vincent's Hospital.

According to information gathered from St. Vincent's Hospital statistical records, 296 teenagers delivered infants in their facility. The age of the mothers giving birth were grouped as follows:

AGE OF MOTHER	14	15	16	17	18	19
# of infants born per age level	2	9	25	57	88	115

In Yellowstone County the local welfare department considers teenagers under 18 years to be their parents' responsibility. If the pregnant adolescent remains in the family home, there is no financial or medical assistance available unless the entire family is eligible. Consequently some teenagers are forced to move from the family home in order to be eligible for medical assistance through Welfare. In 1974 only 35 teenagers under 18 years of age received medical benefits through Yellowstone County Welfare. These pregnant teenagers may not have been delivered in Yellowstone County as there are other residential facilities for unwed mothers throughout the State. There were 88 teenagers who delivered at St. Vincent's Hospital and received financial assistance for medical care from their local welfare agency. Most teenagers are not usually covered for pregnancy under their parent's insurance. Many have not been married long enough to have insurance coverage through a family policy. In many instances these mothers simply do not have the means to carry health insurance nor is health insurance given a high priority by this group. St. Vincent's Hospital has estimated that only five of the teenage pregnancies were fully covered by insurance.
After considerable effort by the Maternal and Child Health Bureau Chief, Local Health Personnel, and Local Physicians, it was generally agreed that the greatest need in Yellowstone County was not in a small selected geographical area, but rather in the realm of teenage pregnancy.

II. PROJECT POPULATION NEEDS

Professions in health care projects and social services view the following as areas of need for the pregnant teenager: early medical care during pregnancy; proper nutrition; basic skills in taking care of the physical needs of a baby; knowledge of social emotional developmental stages of children; knowledge regarding parenting skills. In a survey done in Billings during May 1975 by a Public Health Nurse, 80% of the teenage girls interviewed indicated they would be interested in prenatal education groups if they were pregnant. However, the health care and social service professionals feel this is not a true indicator of actual desire of the service. In presently existing prenatal education classes only about 10 - 15% of the total pregnant teenagers are participating in the group's educational program. General program emphasis will be directed to include the needs of the teenage father who is usually ignored in most school age parent programs.

III. GOAL

To improve the outcome of teenage pregnancy and early parenthood, by providing nursing, nutrition, and social work intervention, and promoting medical and educational services which address to the special needs of teenage parents on a county-wide basis.

A. OBJECTIVES

1. To coordinate services rendered with the following agencies also concerned with the target population: SRS, City-County Health Department, Family Planning, obstetricians, pediatricians, by October 1, 1975, at a cost of $6.30/hour.

2. To develop by July 1, 1976, a definition of need in nutrition, social services, medical care, dental health, and nursing service to be used for planning of project direction at a cost of $6.30/hour.

SECTION V. PROGRAM OF PROJECTS A. (continued)

3. In the target area to provide nursing, social, nutritional, dental, and medical services - not including treatment services- to 100 teenagers and their infants at a cost of $100 per patient.

a. Decrease premature births from 97/1000 to 92/1000 by 7/1/77.
b. Decrease infant death from 27.5/1000 to 23/1000 by 7/1/77.
c. Decrease fetal deaths from 14/1000 to 11/1000 by 7/1/77.
d. Decrease complications of pregnancy from 21/1000 to 16/1000 by 7/1/77.

IV. RELATIONSHIP OF M & I TO STATE DEPARTMENT OF HEALTH

The Montana State Department of Health and Environmental Sciences, Maternal and Child Health Bureau has the total overall legal responsibility and administration for the M & I Project. All Maternal and Child Health Bureau Central office staff are responsible for consultation and supervision within the realm of their expertise. Ultimate authority for the M & I Project rests upon the Director of the Department of Health and Environmental Sciences through the Maternal and Child Health Bureau Chief.

All M & I staff are employees of the State Department of Health and Environmental Sciences, Maternal and Child Health Bureau, and receive the same benefits as any other Department of Health employee. On the local level, the project staff are directly responsible to the project coordinator.

An MCH consulting board of local people was established to assist State Department of Health and Environmental Sciences in establishing an M & I Project (Appendix C). By law Boards have been established for the express purpose of designating proper responsibilities to this Board (Appendix D).

V. STAFFING

A. Project Coordinator is administratively responsible to the MCH Bureau Chief and is responsible for the complete operation of the M & I Project. The duties are as follows:

1. Administrative coordinator of the Project.
2. Coordinates development of informational materials and procedural manuals for local community use.

3. Arrange local agency participation.
4. Provides for efficient channeling of application, intake, medical and social examination.
5. Maintain efficient, concise records of applicant's services rendered and disposition of patient.
6. Report to MCH Bureau Chief and local MCH Board on all Project questions.

B. Administrative Aide duties are:
1. Keep proper financial records of Project operations in cooperation with State Department of Health and Environmental Sciences.
2. Supervise preparation and processing of payment vouchers.
3. Prepare statement of operations and submit as requested by State MCH Bureau Chief.

C. Project social worker is responsible as follows:
1. General supervision of all Project social services.
2. Provide direct social work services.
3. Development and use of social intake evaluation forms and other forms for social data.
4. Tabulation and audit of all social work activity.
5. Coordinate with Department of Social and Rehabilitative Services as needed by teenager for payment or relinquishment.
6. Work with groups as needs arise, such as with fathers.

D. Project public health nurse has the following duties:
1. Develop and organize nursing aspects of the Project.
2. Participate with other Project staff members in writing and publishing Project procedural guides, information, booklets, etc.
3. Devises and implements nursing methods and procedures peculiar to Project objectives and devises and implements reporting and evaluative mechanisms on all Project nursing activities.
4. Works with City-County Health Officer, hospital nursing staffs as consultant and advisor.
5. Provides direct services involving home visits, hospital visits, and child health supervision.
6. Coordinates or assists at clinics as appropriate.
7. Works with physicians in establishing medical care policies and procedures.
8. Develops in coordination with other staff members educations programs, prenatal, postnatal, parenting.
9. Active in group and individual education.
10. Assesses dental priorities and refers.

E. Project Nutritionist is responsible for:
1. Development of nutritional consultation to Project. This entails work with obstetricians, pediatricians, community health nurses, etc.
2. Designs and implements methods for group and individual nutrition education for Project patients.
3. Consultant to other staff members regarding participant nutrition.

4. Assesses individual clients nutritional patterns and helps formulate change if needed.
5. Active with groups and individuals in nutrition education.

F. Pediatrician:
1. Advises Project regarding pediatric component of Project.
2. Conducts child health exams, arranges medical consultation and follow-up where indicated.
3. Helps coordinate services with other pediatricians.

G. Obstetrician:
1. Serves as obstetrical consultant to Project.
2. Helps to coordinate obstetrical services.
3. Participate directly in patient care as one of the Billings obstetricians attending Project patients.

H. Chief of Dental Bureau, State Department of Health and Environmental Sciences:
1. Offers consultation.
2. Provides training sessions as needed.

I. Consulting Staff:
1. Obstetrician: six obstetricians in Billings, one serves as Project consultant. Project clients will receive medical care and delivery from the obstetricians.
2. Pediatricians: Project Consultant and eight others. Examine baby in hospital, discharging them and participating in medical care for the first year of life.

VI. DENTAL HEALTH

Services will include a dental screening and classification by nurses.

Free toothbrushes will be available to participants. Dental health will be integrated into perinatal groups and/or to individuals. Dentitional development during the first year of life will be included.

Dental treatment services will be limited to referrals to local dentists and authorization for payment only with estimates submitted in advance and only to cover infection or pain.

VII. LOCATION

The M & I Project will be a natural extension of Maternal Child Nursing Program, Montana State Department of Health and Environmental Sciences that has been operating in Billings for six years. The office is centrally located next to Planned Parenthood and near the City-County Health Department.

The City-County Health Department employs approximately 20 nurses who will aid the Project in community and clinic work.

The main office will be located at 2718 Montana Avenue, Billings, Montana. Assessments as desired will be done at this location. Outreach by public health nursing, social services, and nutrition will be done county-wide by M & I staff or with the assistance of the City-County Health Department. Educational services such as, high school education programs, perinatal groups, and parenting groups, will be done in areas county-wide as the need is assessed and staffing is available.

VIII. PROMPT DELIVERY OF CARE AND SERVICES:

One of the major efforts will be to provide any and all of the services the patient is eligible to receive in a prompt, orderly manner after registration.

IX. CASE ELIGIBILITY:

Any teenager in Yellowstone County is eligible for services under the M & I Project. Educational material shall be available for both males and females as requested.

In the event that caseload priorities become necessary within the pregnant teenage group, the following guide will be used with third party payments being investigated:

1. Teenagers under 17.
2. Teenagers with medical indications of high risk.
3. Teenagers with social, cultural, or intelligence criteria that would lead to a hazardous pregnancy.
4. Teenagers from low socio-economic background.

Participants in the treatment services must be on the program prior to their fifth month of pregnancy and be willing to receive care by an obstetrician. They will be expected to participate in at least five informational sessions either group or individual. Treatment services including labor and delivery services and correction of defects will be available only to women and infants who would not otherwise receive them because they are from low-income families or for other reasons beyond their control.

SECTION V. PROGRAM OF PROJECTS A. (continued)

Predicting the number enrolling is difficult. One hundred for project services may be anticipated. Payment for treatment services must still be coordinated with local obstetricians. Some alternative plans which may be reviewed by them are enclosed.

$9,500 is designated for contracted services. Approximately $5,000 per year will be used for obstetricians services. One alternative would be to pay part for 50 low-income teenagers with no third party resources. It may be done as follows:

20 patients at 10% of $400	=	$ 800
20 patients at 25% of $400	=	2,000
5 patients at 50% of $400	=	1,000
4 patients at 75% of $400	=	1,200
1 patient at 100% of $400	=	400

Another alternative would be to pay 100% or $400 for twelve women. The income range chart will be used along with individual counseling to determine financial need. (See Appendix L)

The obstetricians developed an acceptable fee for services in January. However, they may wish to resubmit or alter this proposal. (See Appendix L) Pediatric care is provided by Maternal Child Health Clinics. Fee-for-service consultans may be authorized. Each case will be reviewed individually.

X. METHODS OF OPERATION 1974-1975

The mechanics of intake and organization of medical and related services will vary somewhat according to individual needs. The following points, however, have uniform and general application:

A. Information Services -

1. Information regarding type and location of Project services is distributed to all obstetricians, social services, health agencies, schools, and other interested agencies and individuals.

2. Initial referrals from the above sources and self-referrals will be make to the M & I office.

B. Case Intake -

1. Intake will include financial evaluation, nutrition assessment, medical and family history taking, physical assessment, evaluation of family situation, role of the putative father, and evaluation of risk factors.

2. Medical appointments will be arranged by Project staff in cooperation with the obstetricians in order to help alleviate the problems of having to wait so long for the availability of medical care.

3. The family situation will be explored as will the role of the putative father. The client will make a decision on her course of action.

C. Prenatal Care and Delivery in Billings -

1. Her alternatives regarding this pregnancy (abortion, adoption, etc.) will be explored. Referral to counseling agencies, i.e., Planned Parenthood, Welfare, Lutheran Social Services will be made. Living as she chooses whether with parents, husband, in a foster or wage home, or with a relative will be explored.

2. A careful history by the Project nurse will be taken to assess the potential risk of the pregnancy and the needs of the patient and infant.

3. A nursing care plan for each patient will be developed to compliment care by a qualified obstetrician.

4. Arrangements for scheduling of care with an obstetrician of the patients choice will be made.

D. Obstetrical Care - Office Fee for Service

1. Obstetrical care will be provided by the six Billings obstetricians. Clients will choose their preference. He will see the clients according to his usual schedule. Between scheduled visits to the obstetrician, Project staff will help coordinate and interpret physician's directions.

2. For the client remaining in the County, the social worker and nurse will cooperatively help arrange medical care, living arrangements, if needed, help with family relationship problems. Consultation to the family regarding parenting skills and care of the infant during the first year of life will be made by the Program staff.

3. Continuing nutritional input for information and formulating change if needed.

SECTION V. PROGRAM OF PROJECTS A. (continued)

XI. PATIENT SERVICES

When the patient is registered on the M & I Project she will be eligible for the following services.

A. Group counseling devoted to the particular medical, social, emotional, nutritional and nursing problems of pregnant teenagers.

B. Certain prenatal care that is offered through the project such as maternity nursing clinics.

Perinatal Behavorial Responsibilities

Have an understanding of the importance of prenatal care and the warning signs which indicate a need for advice or attention.

Understand and behave in a manner consistent with good prenatal development.

Be aware of the alternatives to unwed pregnancy and child rearing.

Understand the birth process and behave in a self-assured and rational manner during delivery.

Be prepared for and aware of the physiological and psychological changes in the immediate post partum period.

C. Social Work Services -

Social services will include but not limited to the following: Individual case work services when indicated; group work will often be provided in conjunction with other M & I staff; diagnostic workup regaring family interaction, personal relationship and environmental impact on the individual and family strengths and weaknesses which will be used in helping the individual assessing own situation and making choices for improvement in his situation.

Since the project has only a half time social worker, it will be the project director or the project social worker's responsibility to determine which priorities the social worker will deal with.

D. Coordination of health services with educational personnel while patient is still informal on vocational training.

E. Nutritional services to determine adequate nutritional needs for both mother and fetus and learning alternatives to compensate for any nutritional needs.

F. The coordination of family planning services provided through Planned Parenthood of Billings.

G. Information group such as prenatal education classes, the Lamaze program for birth, and discussions on parenting and problems associated with being a parent.

H. Child Health Services - These services are available for certain congenital malformations the pregnant teenager may have and is receiving corrective treatment. The infants born with congenital malformations to mothers registered on the M & I Project will be eligible for Child Health Services if the malformation is one covered through Child Health Services (See Appendix P)

I. Transportation is available to help the patient keep appointments at the M & I Project, obstetricians's office, and the hospital.

J. Home-maker services will be available to assist the patient in developing home-making skills before and after delivery.

K. Child Care -

Beginning to understand the growth and development process with emphasis on the first year of life.

Behave in a manner which will encourage health development of the child during the first year.

Recognize deviations in the first year and understand the appropriate use of medical care.

Understand and be able to make informed decisions about family planning.

SECTION V. PROGRAM OF PROJECTS A. (continued)

XII. OTHER AVAILABLE RESOURCES

In response to the special needs of the teenage population being served, child care will be available during group meetings. This will be provided by different groups (such as the YWCA, Staff, Neighborhood Youth Corp, etc.).

The City-County Health Department through CETA will provide trained home health aides at no charge to help meet needs of the Maternal Infant participants.

Transportation services will probably be necessary for many participants to insure continuity of health care and informational services. Alternatives and community resources will be explored. Transportation will be provided by staff members if no alternatives are discovered.

Teenage mothers may remain in public high school or attend night high school. Vocational counseling and training is available through WIN and vocational services. These options will be reviewed with clients where applicable.

The WIC Program, a health and nutritional program, will be available to all clients during the pregnancy and to the babies. It provides foods, nutritional counseling, and a commitment to health care. This Program has been available to Yellowstone County residents for under three months and has 1,200 enrollees. (See Appendix F).

Planned Parenthood of Billings has the available services to do pregnancy testing, counseling regarding decision, and guidance in future family planning. They have agreed to allow the Project to use examining rooms as needed. Planned Parenthood as a community agency has contact with many teenagers each month. They are an important source of referral to us. (See Appendix N)

XIII. EVALUATION

Complete records will be kept on all patients so that the following may be compiled and analyzed:

A. Medical complications - type, severity, correlation with age, prenatal care, attitudes, pregnancy outcome, etc.

B. Length and adequacy of prenatal care and its effect and outcome.

C. Effect of counseling on adoption rates.

D. Educational and vocational changes accomplished by the Project - semester completed, subsequent follow-up of education, vocational preparation, job placement, etc.

E. Social counseling effect on subsequent marriage, family relationships and community attitudes.

F. Study of incidence of teenage pregnancy.

G. Study of significance of factors and problems confronting the teenage mother.

H. Study of putative father involvement.

Very few base lines an be identified at present and those working with teenagers cannot now accurately estimate the number of individuals that will take advantage of the services offered. Experience in other states and the literature on the problems are difficult to relate to a rural state. It is planned that studies resulting will be made in four problem areas:

A. Statistical analysis of unwed mothers - how many, who, where, what kind, and why?

B. Analysis of medical problems peculiar or at least common to this group. Also, the statistical type of factors to be expected - weight, complications, genetic characteristics and abnormalities, etc.

C. The social needs of these unwed mothers and what are the important areas of emphasis for counseling and guidance. What are their backgrounds, their maturation and their chance of later emotional, vocational and economic success?

SECTION V. PROGRAM OF PROJECTS A. (continued)

D. Administrative policies and procedures best able to efficiently operate such a program in a state such as Montana.

There will be a quarterly monitoring system to report current progress developed by October 1975.

Data will be collected to be able to address relevance to the measurable objectives listed in III, A.

XIV. ASSURANCES

The following assurances are provided as required in the Federal Register, Vol. 40, No. 58, Section 51a, 123c.

1. The Maternal-Infant Care Project will have available and provide services to all pregnant teenagers in Yellowstone County. South Billings is a high risk area as shown by the survey done for the Project. Lockwood and Billings Heights have many trailer villages with concentrations of low-income people. North Park, Industrial Avenue, and west of 24th Street and Central Avenue are areas with Federally financed low-income housing. These areas have a high concentration of broken homes and welfare recipients.

   The Maternal-Infant Care Project office borders the South Billings area. Child Health Clinics are offered through the Maternal Child Nursing Project. They are centrally located in the South Billings area in Guadalupe Church and in the North Park area in the Naval Reserve Center.

   The Maternal Child Nursing office, Guadalupe Church, and Friendship House are being looked to as sites to assure availability of services in the South Billings area. (See objective page.) The YWCA, Naval Reserve Center, churches, and schools are possibilities in other areas of the County.

2. Diagnostic and preventive prenatal and postnatal services are available without charge to women through Planned Parenthood services. A small fee is levied according to ability to pay but no one is refused pregnancy testing, pregnancy verification, family planning information, counseling, or supplies. Maternal and Infant Care Project enrollees are assured of this. (See attached letter.)

   The Maternal Child Nursing Project through already existing Child Health Conferences will provide without charge to all infants, immunizations and well-child examinations including assessment and diagnosis of special conditions as needed. Dr. Hagmann is the pediatrician and Lark Hackney, the nurse practitioner in these clinics.

3. Maternal and Infant Care funds for treatment services are limited as are funds for personnel. Treatment services will be available only to women and infants who are designated target population who would not otherwise receive them because they are from low-income families or for other reasons beyond their control. Medicaid and health insurance will be explored as possible sources of payment. Montana Crippled Children Services will be explored as a possibility in the event correction of an infant defect is required. A fee schedule in an attempt to serve the most people with the most need is being developed.

4. Services will be expanded outside the target population only if it is determined by the Project Coordinator that provision of such services will best promote the purposes of the program and as funds permit.

5. Treatment will be provided to women and infants who are not from low-income families but who would not otherwise receive such services for reasons beyond their control only if such treatment does not reduce the delivery of necessary services to women and infants from low-income families. In those instances where charges are made for treatment

services provided to women and infants who are not from low-income families, such charges shall be applied flexibly with due regard to family size and income and the family's other financial responsibilities in relation to the cost of required care. Full disclosure of such payment scales and the factors by which they are applied shall be made available to payors and providers as well as to the patients and their families. The established basic payment schedule shall not exceed actual costs.

Where eligibility has been established by a staff member consulting with a third party payor, the third party payor will be responsible for authorization of payment. Staff members confirming eligibility for third party payments will in individual cases clarify this with participants and payors.

6. The Maternal and Infant Care Project will be administered by the State Maternal Child Health program unit directly. Local coordination will be through the Yellowstone City-County Health Department Director, George Sheckleton, M.D., and the local board. The local Coordinator, with responsibility for overall direction of the Project, is Lark Hackney, who is a full-time employee of State Department of Health and Environmental Sciences.

7. Edward Hagmann, M.D., Pediatrician, and Lee Raitz, M.D., Obstetrician, will serve as consultants in appropriate areas of the Project. However, the Medical Director for the Project is the Chief of the MCH Bureau.

8. Determinations of eligibility for services will be made by the Project Coordinator or a member of the Project staff designated by her and in accordance with these regulations and the policies and procedures promulgated, thereunder, and in accordance with the approved State plan.

9. If it is found, funds are inadequate for the provision of necessary health care, the program will be curtailed in terms of area or population served, or similar factors and not in terms of the care and services provided under the program.

SECTION V. B. NEWBORN INTENSIVE CARE PROJECT

A. GOAL

To reduce infant mortality and morbidity in Montana by providing the specialized comprehensive care needed for infants who are born at risk, potentially at risk, or who become at risk during the first year of life.

B. OBJECTIVES

1. To develop a multidisciplinary team approach in providing evaluation, treatment, and follow-up care of the high-risk/acutely ill infant. The team shall include, but not be limited to physicians, nurses, nutritionists, dietitians, social workers, public health nurses, ambulance operators, and parents.

   a. There shall be a team made up of personnel from the State Department of Health and Environmental Sciences who will be responsible for establishing a uniform statewide NBIC Program.

   b. Consulting committee to the State Department of Health and Environmental Sciences made up of members of the four local NBIC facilities and other invited persons.

   c. Each Level II unit will have a multidisciplinary team as outlined above.

2. To participate in the development of intermediate care centers (Level II) for the high-risk/critically ill infant in Billings at St. Vincent's Hospital, Butte at St. James Hospital, Great Falls at Deaconess Hospital, and Missoula at Community Hospital by June 30, 1976. Each facility will provide:
   a). Skilled medical staff.
   b). Fulltime skilled nursing staff and adequate nurse to patient ratio.
   c). Adequate nursery facilities with up-to-date equipment.
   d). Services of a skilled registered dietition.
   e). Services of a skilled social worker.
   f). Adequate support services such as laboratory, pharmacy, and therapists - inhalation, physical, etc.
   g). Invitation to expert consultants for training and evaluation purposes which will result in:
      1). Decreased morbidity and mortality of infants cared for in the Level II unit.
      2). Decrease area-wide morbidity and mortality rates.
      3). Increase comprehensiveness of services provided.

3. To develop a rapid, effective newborn transportation capability in Montana to transfer 200 newborns by January 1, 1976, to include:

(Continued)

a. Nursing staff trained in the care of acutely ill infant to accompany the infant in the transport vehicle to the intensive care center.

b. Transport incubator available for use by the transport vehicle.

c. Transportation personnel trained in the problems of infant transport.

d. Vehicles of recommended size and equipment.

e. Full time availability.

Which should result in:

a. A decreased risk of morbidity and mortality due to the hazards of transportation.

b. Ability to reach all newborns in need within 1½ hours.

c. Increase use of the regional centers by the outlying hospitals to 25% of the high risk infants in one year and 10% of the high-risk mothers.

4. To develop by January 1, 1976, a referral capability to major centers in Denver, Salt Lake City, and Seattle that is orderly, efficient and rapid which will result in the ability to safely transport the infants unable to be adequately cared for at the intermediate centers within three hours from the intermediate center.

5. Development and implementation by January 1, 1976, plans for evaluation of care in primary care facilities and offering on-site educational opportunities to the staff of each utilizing resource people from the state's intermediate care facilities. This may be supplemented by training within the Newborn Intensive Care Centers. Plan to offer this service to 25 primary care facilities by July 1, 1976. Emphasis will be placed on reaching high-risk communities. This should include the following:

a. Survey of availability of equipment.
b. Assessment of care level.
c. Training of nurses and physicians in the ability to identify high-risk mother and infant.
d. Training of nurses in competency for care of the acutely ill newborn.

SECTION V. B. NEWBORN INTENSIVE CARE PROJECT

(Continued)

e. Training of physicians in neonatology as relates to their setting which will result in:
   1). Decrease infant mortality rate in the State from 21.6% to 21% by July 1, 1976.
   2). Increase ability to give up-to-date care for the acutely ill newborn as determined by "Guidelines for Newborn Care in Montana," and "Proposed Standards for Perinatal High-Risk Nursing in Secondary Centers."
   3). Increase use of the regional centers by the outlying hospitals to 25% of all high-risk infants and 10% of high-risk mother by July 1, 1976.

6. To develop by July 1, 1976 plans for the continued training of the personnel involved in the specialized care at the intermediate care centers through:
   a. Utilization of the State Department of Health & Environmental Sciences, Health Education Services.

   b. Utilization of out-of-state training programs.

   c. Purchasing consultation services from medical education centers, to be brought to the state to provide workshops and evaluation visits to care facilities.

   d. An exchange of information and peer review between professional personnel within the state's intermediate care facilities.

7. To develop a statistical reporting system to evaluate the activities, effect, quality, and impact of the programs by July 1, 1976.

8. To communicate with all of the agencies and individuals involved in neonatal care in Montana, and coordinate their activities and services by January 1, 1976. (M.M.A., Private Agencies, R.M.P., LHD, etc.)

9. To develop and implement by July 1, 1976 a plan for continuation of care after infants are discharged from the hospital. The development of this plan will involve the M. C.H. nursing consultant from Wyoming because one-third of the babies cared for in the Newborn Intensive Care Unit in Billings come from Wyoming.

10. To develop by July 1, 1976 a system for Social Services within NBIC sites in Montana which can provide the necessary services to families in dealing with the social, psychological, and economic impact of having an ill newborn.

(Continued)

11. To develop by July 1, 1977 a system for nutrition services within WBIC sites in Montana which can provide the necessary services of nutrition consultation to hospital staff and parents while the infant is in the hospital and, also, provide supportive nutrition consultation to parents during the infant's first year of life.

C. ASSURANCES

1. Services of the Newborn Intensive Care Project are available to any family that needs the services, but an effort will be made to reach areas of concentration of low-income and areas with greater needs as shown by morbidity and mortality statistics.

2. Services will be available to all infants who are at high-risk. Families who are able to pay for services will be expected to do so.

3. There are no residential barriers to the provision of services. Families from Wyoming who live within the Billings trade area utilize the services. Services to families or individuals residing outside of the State of Montana will be provided only if the Project Director determines that the provision of services promotes the purpose of the project.

4. Because of unavailability of equivalent services within the area, infants not from low-income familes will receive services of the NBIC Programs. Charges to such families shall be applied flexibly and with due regard to family size, income and other financial responsibilities in relation to the cost of required care. Full disclosure of payment scales and the factors by which they are applied shall be available to payors and providers as well as to patients and their families. The established basic payment schedule shall not exceed actual cost. Every reasonable effort will be made to collect from third-party payment sources (including government agencies) which are authorized or under legal obligation to make such payments.

   When the costs of care are to be reimbursed by a government agency, a written agreement with that agency shall be established, and reimbursement will be made to the project or directly to the provider in accordance with this agreement.

5. The Newborn Intensive Care Project will be administered by the Maternal and Child Health Bureau of the Montana Department of Health and Environmental Sciences. Each Program will be under the direction of a single full-time director who is responsible for overall direction of the program.

(Continued)

6. Medical care and services provided by each program will be under the direction and responsibility of a physician with appropriate training and experience.

7. Determination of eligibility for care will be made by the program director or one of the staff designated by him and will be in accordance with the ACT, HEW regulations, and policies and procedures promulgated thereunder, and in accordance with the State Plan.

8. To the extent that funds are inadequate for the provision of necessary health care, the project may curtail certain activities. The quality of care and services provided under each program will be maintained at its highest level.

9. Nutrition counseling and/or consultation will be provided or arranged as requested, depending upon availability of local resources and the needs of the individual patients and the personnel providing care.

10. Social work services will be provided, developed, or arranged, depending upon availability of local resources, and the needs of individual patients, and the care providing personnel.

11. Services will be available to those infants from outside the project area only if the project director determines and promotes the purpose for which these services are provided.

D. DEVELOPMENT OF INFANT TRANSPORT SYSTEMS

Infant transports are based at all four hospitals, Billings, Butte, Great Falls, and Billings. These systems include the necessary equipment to transport the infant except the vehicle. In each case the mode of transportation is furnished by private ground and/or air ambulance companies. Air ambulance is used when distance and weather permit. Otherwise ground ambulance is used. The families are expected to pay for the ambulance costs except as outlined below in items six and seven.

Some of the important aspects of the transporting systems are:

1. Experienced Newborn Intensive Care nurses are on call 24 hours a day to accompany seriously ill infants during transport.

(Continued)

2. By placing one phone call, a hospital or physician can activate the transport team. The team will make all arrangements, dispatch the ground or air ambulance, incubator and nurse, and contact the consulting pediatrician chosen by the family of the infant.

3. The mode of transportation, whether ground or air, will be decided by the transport team with consideration of four factors:

   a. Condition of the infant.
   b. Travel time for the infant usually not to exceed approximately two hours.
   c. Safety
   d. Economy

4. A transport incubator is maintained in ready condition at all four hospitals and have provisions for:

   a. Supplying its own oxygen and heat.
   b. Monitoring ambient oxygen, infant temperature and heart rate.
   c. Regulating intravenous fluids.

   Transport in the incubator is limited to infants newly born or still under 12½ lbs.

5. The transport team will not rush departure from the referring hospital until they have assessed the infant's condition, begun intravenous fluids, placed an oro-gastric tube, attached monitors, and feels certain the infant's condition is stable for transport. The team will bring all necessary supplies. They may contact the consulting physician by telephone or ambulance radio if necessary.

6. Limited funds (currently $50 per trip) for the services of the transport team will be provided by the Montana State Department of Health and Environmental Sciences for Montana children. The cost of the ground or air ambulance must be borne by the family and third party agencies except for those families determined eligible for financial assistance for ambulance transportation.

7. Eligibility for financial assistance for ambulance transportation is determined by using the same procedures and criteria as eligibility established for the Child Health Services program.

(Continued) #7

The social worker at the four Level II hospitals (Billings, Butte, Great Falls, and Missoula) will take the parents application on the regular Child Health Services application form as soon as possible after the infant is admitted to their facility. In order to keep Maternal and Child Health Bureau informed, as soon as the request for the transportation team comes to the hospital, the social worker should telephone MCH Bureau, Phone 449-2554, and inform the Bureau that there may be a request for financial help for air transportation and leave the patient's name and community.

8. To minimize the negative affects of separating parents and infant, we encourage both mother and father to visit the Intensive Care Nursery as soon as possible to see and handle the baby. Every effort will be made to keep parents and the referring hospital informed of the infant's condition. If ground ambulance is used for transport, a parent may accompany the infant to the hospital. Air ambulances, however, ordinarily are not spacious enough to allow this.

9. Some communities will wish to resume care of the infant as soon as possible. In this circumstance the infant will be dismissed to the home hospital after it has passed the critical period. Otherwise the infant will be returned directly to its home. A comprehensive program of follow-up services will be available in the future.

10. Physicians and hospital staff from the outlying communities are encouraged to visit the Intensive Care Nursery. Nurses, dietitians, and social workers may wish to spend a day or two working with the Intensive Care and Newborn staff. As funds again become available, we hope to resume visiting community hospitals to share ideas and educational programs.

11. The program in no way excludes the transport of less ill infants to the hospital by parents or community ambulance when this is sufficient.

12. Despite the transport program, the mother is still the best "transport incubator." If at all possible, the high-risk mother should be transferred to a specialized care facility before delivery.

SECTION V. B. NEWBORN INTENSIVE CARE PROJECT

E. REFERRAL PROCEDURES

The local hospital or physician wishing to activate the Infant Transport System should proceed as follows:

1. Choose a consulting pediatrician.
   a. Billings: The participating pediatricians are
      Marion A. Jones, Phone 252-5654
      Allen Hartman, Phone 252-4141
      Paul R. Crellin, Phone 252-6601
      Patrick J. Sauer, Phone 252-4141
      Dean W. Wilcox, Phone 252-4141
      John A. Whittinghill, Phone 252-6601
      Nick R. Yenko, Phone 252-6601

   b. Butte: Participating physician-
      Dennis McCarthy, Phone 723-5474

   c. Missoula:Daniel J. Combo, Phone 542-0391
      Harold C. Schwartz, Phone549-8570
      James Law, Phone 542-0391

   d. Great Falls - At the Great Falls Clinic ask for
      Jack Haling, Phone 454-2171

2. For the transportation team call the following number and ask for the transportation team. The individual receiving the call will ask identifying information and inform you of the approximate arrival time of the ambulance.

   The numbers are:
   a. Billings - Phone 252-2121, Extension 416
   b. Butte - Phone 723-5474, Dr. McCarthy
   c. Missoula - Phone 542-0391, Dr. Combo
   d. Great Falls - Phone 761-1200, Extension 2311

3. Have ready for the transport nurse on her arrival:
   a. Reproduction of the prenatal history, birth record, and nursery record, or information for the "Infant and Family History."
   b. 10cc of mother's blood (clotted)
   c. any x-rays taken of infant
   d. Cord blood, if available.

4. Request parents be available to discuss plans and sign a consent for the infant's admission to the hospital.

5. Give the transport team a report of the infant's status and treatments already begun.

SECTION V. C. FAMILY PLANNING

A. OBJECTIVES

1. Implementation of a peer review system to act as a quality of care mechanism by evaluating each program by September 1976.

2. To help assure adequate financial resources by maintaining sources of funding, other than Title X, which account for at least 35 percent of the cost of family planning services in one year.

3. Improve family planning management as evidenced by a five percent decrease in the average cost per patient with the 15 family planning programs.

4. Provide board training for six local boards to afford an opportunity for consumer participation in the development, implementation and evaluation of local family planning programs.

5. Provide educational programs which were suggested as priorities in the needs assessment for training.

6. To provide health education assistance to two communities with a high rate of early teen pregnancies in order to reduce the rate to below the state average by June 1978.

B. PROGRAM EVALUATION FOR FY 1976

The number of patients seen in the family planning project has continued to increase during FY 1976. To assure high quality of care being received by these patients, a protocol for peer review was developed. A major success during the year was the acknowledgement of the importance of family planning by the state legislature, which, for the first time, appropriated $30,000 a year to family planning to be used as match for Title XX funds.

The major problems during the year were the financial restrictions caused by a reduction in the amount of Title X funds available during FY 1976. Programs which had hoped to be able to expand into outlying areas were unable to do so. The proposed program in Rosebud County was not started because of the shortage of funds. Funding is now being sought from the Old West Regional Commission to open a family planning program in Rosebud County. There is a great need for a program in this coal development area, but so far, we have been unable to meet this need because of the shortage of Title X funds.

GOAL #1 - TO IMPROVE THE HEALTH OF TEENAGE WOMEN.

Progress toward meeting this goal cannot be evaluated until the appropriate vital statistics for 1975 have been gathered and analyzed. The statistics for 1975 will not be available until early 1976. However, it is unlikely that the family planning project during FY 1976 had much impact on this objective. A one-year time period is too short for any program to show a change in teenage out-of-wedlock rates and second and higher order pregnancies. In addition, restrictive state laws make it difficult to provide family planning services to minors who seek such services.

GOAL #2 - TO DEVELOP ALTERNATIVE SOURCES OF FUNDS FOR THE FAMILY PLANNING PROGRAM TO ASSUME 35 PERCENT OF THE COSTS FOR FAMILY PLANNING SERVICES IN ONE YEAR.

The Department of Health and Environmental Sciences has signed a contract with the Department of Social and Rehabilitation Services to provide family planning services at a cost of $278,150 in Title XX funds. Title XX plus fees equals more than 35 percent of the costs of family planning services yearly. The objectives has been met.

GOAL #3 - TO DEVELOP INTERNAL MECHANISMS FOR ASSURING QUALITY OF SERVICES TO 12,000 CLIENTS BY:

a. Development of MBO procedures in three pilot projects. This objective has not been implemented. Technical assistance which has been requested from the regional office was not available. Efforts which had been planned to be used on this objective had to be reallocated to take care of unforeseen difficulties in finalizing the Title XX contract.

b. Development of problem-oriented records in eight project.

   Most of the family planning programs in Montana are using some type of problem-oriented records.

c. Development and implementation of protocol for peer review assessments.

   A protocol has been developed and field tested.

d. Develop nurse practitioner capability in eight projects.

   Nurse practitioners or women's health care specialists are currently working with or in training to work with the following projects:

Missoula	Butte	Deer Lodge
Helena	Bozeman	Great Falls
Havre	Glendive	Billings

e. Develop cost analysis procedures in all projects as a means of comparing year-to-year the individual project against itself.

Cost per patient figures are available for each project and were one of the factors used to determine the allocation of Title XX funds. Additional cost accounting procedures will be developed during the coming year.

GOAL #4 - TO PROVIDE EDUCATION IN THE AREAS OF FAMILY PLANNING AND PREVENTIVE HEALTH.

The health educator in the state family planning program was trained as a trainer for local family planning boards. Communication workshops with local family planning staffs were conducted. The local family planning programs conducted school and community education as well as patient education.

GOAL #5 - TO PROVIDE SOCIAL SERVICES AND COUNSELING.

Social services and counseling were provided to 3,100 patients under the IV-A contract with the Montana Department of Social and Rehabilitation Services.

GOAL #6 - TO PROVIDE STATEWIDE TRAINING CAPABILITY.

The health educator is presently taking additional training through the Trainer Development Program. At the completion of that training, the need for a statewide training team will be re-evaluated.

C. DESCRIPTION OF PROJECT

In Montana there are presently 15 local family planning programs which receive support through the Montana Department of Health and Environmental Sciences, Maternal and Child Health Bureau. Funding for family planning is provided to the Department of Health and Environmental Sciences by federal Title X monies. As the grantee, the department has taken the responsibility for assuring that the 15 local family planning programs which it supports provide family planning services according to the requirements of Part 59, Sub-part A of the PHS Manual Laws and Regulation.

The 15 local family planning programs which provide the direct services to patients are listed in Attachment A. These programs offer the following preventive health services:

--- Counseling in all aspects of family life.
--- Educational services.
--- Blood tests for anemia, rubella and syphilis.
--- Immunizations for rubella.
--- Blood pressure recordings.
--- Physical examinations.
--- Cervical cancer screening.
--- Gonorrhea screening and treatment.
--- Pregnancy tests.
--- Urine analysis for sugar and protein.
--- Breast self-examination instructions.
--- Diagnosis and treatment of vaginal infections.
--- Infertility examinations.
--- Dispensation of contraceptive devices.
--- Payment of some voluntary sterilizations.

The minimum standards of health care in family planning are described in Attachment B. Adherence to these standards will be monitored through site visits to the local family planning programs by staff of the Maternal and Child Health Bureau. Quality of care in the local programs is also assured through the peer review system, which will provide a mechanism for evaluating each program annually.

Each individual program is responsible for developing its own objectives relating to the statewide plan and of describing its activities, functions and work guidelines.

ATTACHMENT A

MONTANA FAMILY PLANNING PROGRAMS

BILLINGS PLANNED PARENTHOOD
Mrs. Joan McCracken, Director
Planned Parenthood of Billings
2718 Montana Avenue
Billings, MT 59101
Phone 122-9-248-3636

CUSTER COUNTY FAMILY PLANNING
Mrs. Colleen Kohn, Director
Custer County Family Planning
Courthouse
Miles City, MT 59301
Phone 133-9-232-3307

DAWSON COUNTY FAMILY PLANNING
Mrs. Lois Sadorf, Director
Box 281
Glendive, MT 59330
Phone 151-1-365-2935

FERGUS COUNTY FAMILY PLANNING-CENTRAL MT.
Mrs. Emma Peterson, Director
Box 1150
Lewistown, MT 59457
Phone 151-1-538-8811

FLATHEAD COUNTY FAMILY PLANNING
Ms. Sue Tarmina, Director
Flathead County Family Planning
21 10th Street West
Kalispell, MT 59901
Phone 136-9-756-7389

BOZEMAN FAMILY PLANNING
Mrs. Sue Sybrant, Director
Family Planning Service of South
Central Montana, Inc.
P.O. Box 1276
Bozeman, MT 59715
Phone 126-9-587-0681

GREAT FALLS FAMILY PLANNING
Mrs. LaVerne Barnes, Director
Cascade County Family Planning
607 11th Street North
Great Falls, MT 59401
Phone 124-9-452-9564

HELENA TRI-COUNTY FAMILY PLANNING
Mr. Royal Johnson, Director
201 South Last Chance Gulch
Helena, MT 59601
Phone 442-3830

HILL COUNTY FAMILY PLANNING
Mrs. Helen Vandeberg, Director
Hill County Family Planning
P.O. Box 1509
Havre, MT 59501
Phone 135-9-265-6744

LAKE COUNTY FAMILY PLANNING
Mrs. Shirley Newell, Director
P.O. Box 778
Ronan, MT 59864
Phone 151-1-676-0900

MISSOULA PLANNED PARENTHOOD
Mrs. Sydney MacIntyre, Director
Missoula Planned Parenthood
Corner of Woody and Alder
Missoula, MT 59801
Phone 125-9-728-5490

PHILLIPS COUNTY FAMILY PLANNING
Ms. Rose Christensen, Director
Phillips County Family Planning
Box 546
Saco, MT 59261
Phone 151-1-654-2078 or 151-1-527-3557

POWELL COUNTY FAMILY PLANNING
Ms. Cecilia Zander, Director
Powell County Courthouse
Box 187
Deer Lodge, MT 59722
Phone 127-9-846-2251

RAVALLI COUNTY FAMILY PLANNING
Mrs. Henrietta Brandon, Director
Ravalli County Family Planning
Ravalli County Courthouse Annex
Hamilton, MT 59840
Phone 151-1-363-3223

ROSEBUD COUNTY FAMILY PLANNING
Mrs. Doris Cartwright, Director
Box 388
Forsyth, MT 59327
Phone 151-1-356-2156

SILVER BOW COUNTY FAMILY PLANNING
Mrs. Becky Harrington, Director
Family Planning Clinic
Family Service Center
25 West Front Street
Butte, MT 59701
Phone 123-9-723-6797

MINIMUM STANDARDS OF HEALTH CARE IN FAMILY PLANNING PROGRAMS

CONTENTS

March, 1972

51a.125 Program of Projects for Family Planning Services

The family planning services projects supported by grants to the Bureau of Maternal and Child Health under Title X of the Public Health Service Act meet the requirements of 42 CFR, part 51a.125, proposed rules, Federal Register, March 25, 1975.

Each item listed under paragraphs (b) and (c) of part 51a.125 is listed separately, followed by a description of the provisions in the State of Montana Family Planning Program developed under Title X which address the item in part 51a.125.

51a.125(b) "The Secretary, in determining whether the program of projects described in the documents incorporated by reference offers reasonalbe assurance of achieving the above-stated objectives, will take into consideration the degree to which the program of projects provides for:"

(1) "Counseling and interpretation to individuals of the services offered by the project, and public education and information services."

Counseling and public education and information are provided for in the "Goal Intents" (p. 3-4) and the "Work Plan and Guidelines for Services Provided" (p. 16-40) sections of the State of Montana Family Planning Program Plan developed under Title X. Training and consultation with personnel within the individual programs so that they may perform the above functions are provided by a health education consultant in the State DH&ES as described in the "State Department of Health Personnel and Support Services", (p. 17) section of the Work Plan. The "Guidelines for Standards of Health Care in the Family Planning Programs" section (p. 31), provides for patients to return whenever they wish for additional guidance. Section VII of the Work Plan, "Health Education Guidelines in Family Planning" (p. 38) outlines the health education services in detail. Section VIII of the Work Plan "Social Service Guidelines in Family Planning" (p. 39) provides for patient counseling and social services reports.

(2) "Medical services that include a medical examination under the direction of a physician with special training and experience in family planning, and the services of allied health personnel."

Section V of the Work Plan, "Guidelines for Standards of Health Care in the Family Planning Programs" describes in detail what should be included in the initial physical exam (p. 21). Section VI of the Work Plan, "Other Medical Services" describes the minimal

medical supervision allowed and includes: physician background and availability and the establishment of policies with reference to the functions of the family planning non-M.D. practitioner (p. 35). The utilization of trained allied health personnel is encouraged (p. 36).

(3) "Comprehensiveness and continuity in the health management and supervision of patients receiving family planning services."

Comprehensiveness and continuity is provided by the Clinic Records and Clinic History (p. 20), the Post-examination interivew (p. 30), the Annual Visits (p. 31) and the Problem Visits (p. 31) described in the "Guidelines for Standards of Health Care in the Family Planning Programs" section of the Plan.

(4) "The prompt delivery of family planning services."

The "Guidelines for Standards of Health Care in the Family Planning Programs" section of the Work Plan provides that "patients should be encouraged to return whenever they have specific problems related to the contraceptive method or wish additional guidance or service, including additional supplies." (p. 31). The "Other Medical Services" section of the Work Plan provides for emergency services when the clinic is not in session (p. 33), for the availability of a physician when the clinic is in session (p. 35), and for instructions to be given to all patients as to where 24-hour emergency care is available (p. 36). Where patients must wait for a scheduled clinic, interim measures are provided for the patient.

(5) "Income standards for determining eligibility for family planning services, which are to be applied flexibly with due regard to family size and income and the family's other financial responsibilities in relation to the cost of such services."

The program evaluation for 1974 in the Plan states that fee for

service systems were implemented in all of the projects (p. 1). All programs participating in Title IVA have been provided with income standards for determining eligibility based on income and family size.

The discussion of Section 50.105(b) of Regulations and Guidelines for Health Services Funding, HEW, November 5, 1974, states that "projects must institute policies...and procedures to determine the ability of patients to pay for all or part of the charges for services rendered." "...graduated payment scales, taking into account at least family size and family income, must also be approved by the awarding authority". Since the above is required for Title X funding it should be sufficient to meet the requirements of 51a.125(b)(5).

The Department of Health & Environmental Sciences has a signed agreement with the Department of Social and Rehabilitation Services to receive Medicaid reimbursement for services provided by the programs to eligible recipients.

(6) "Staff and/or consultants in the state maternal and child health program, or in each project, that will insure adequacy of services."

The "State Department of Health Personnel and Support Services" section of the Work Plan outlines the staff and consultants in the state maternal and child health program that insure adequacy of services (p. 16-18).

(7) "Arrangements for the provision of services for those women within the area served by the program of projects for whom the program of projects cannot provide care."

In the "Other Medical Services" section of the Work Plan (p. 31) specific circumstances are listed in which the project is responsible for referrals, even though the services cannot be supported with project funds.

(8) "The coordination of health care and services provided under the programs with, and the utilization (to the extent feasible) of, other health and welfare resources."

In addition to the information discussed under 51a.125(b)(7), the programs provide referrals to other counseling agencies when necessary (p. 3). The programs cooperate with the Department of Social and Rehabilitation Services by providing services to Title XIX recipients. (See discussion under 51a.125(b)(5).

51a.125(c) "The State plan also shall contain the following assurances:"

(1) "That the program of projects will provide services particularly in areas with concentrations of low-income families with priority given to areas having the greatest need for such services, whether urban or rural."

The twenty-five counties (45% of the counties) covered by family planning programs account for 73% of the number of ADC potential females aged 15-44 in Montana.

The traditionally low-income populations on Indian reservations are provided family planning services through the Indian Health Service.

(2) "That a variety of medically approved methods of family planning, including the rhythm method, will be available and supplied to all persons within the area served by the program of projects."

The "Health Education Guidelines in Family Planning" section of the Work Plan says that an overview of methods of contraception, including the rhythm method, will be available (p. 38).

(3) "That family planning services and supplies include at least physician's consultation, examination, and continuing supervision, necessary laboratory examinations and tests; medically approved contraception through chemical, mechanical, or other means; surgical procedures for voluntary sterilization; and evaluation of couples for infertility and referral to other appropriate resources when services are not provided by the project."

The "Guidelines for Standards of Health Care in the Family Planning Programs" (p. 20-31) and the "Other Medical Services (p. 32-36) sections of the Work Plan show that family planning services and supplies include all of the items specified in 51a.125(c)(3).

(4) "That treatment services will be available only to women who otherwise would not receive them because they are from low-income families or for other reasons beyond their control."

As stated in the State of Montana Family Planning Program, 80% of the clinical patients served were medically indigent - not on welfare but low-income (p. 20).

(5) "That services will be provided without regard to age or marital status."

The policy statement on treatment of minors, according to Montana state law, is on p. 40 of the State of Montana Family Planning Program. Marital status is not considered when providing services to persons 18 or over.

(6) "That services will be available to women from outside the area served by each program only if it is determined by the program director that provision of such services will best promote the purposes of the program of projects under this section."

Residency in a county providing family planning services is not a prerequisite to receiving services. Services to persons living outside the service area are provided if it is determined to promote the purposes of the program.

(7) "That services will be provided to women who are not from low-income families but who would not otherwise receive such services for reasons beyond their control only if the provision of such services does not reduce the delivery of services to persons from low-income families..."

Persons from low-income families constitute the target group for family planning services. Eighty percent of the clinical patients served were medically indigent. However, services are available to anyone seeking them, except within the constraints imposed by state law regarding minors. For information on charges, see the discussion under 51a.125(b)(5).

(8) "That the program of the projects will be administered by the state maternal and child health program unit, either directly or through grants or contracts..."

The organization of the family planning program is described on pages 15-18 of the State of Montana Family Planning Program.

(9) "That family planning medical services provided by the project will be under the direction and responsibility of a physician with appropriate training and experience."

Assurances regarding the above may be found in the "State Depart-

of Health Personnel and Support Services" (p. 16), the "Guidelines for Standards of Health Care in the Family Planning Programs" (p.20-31) and the "Other Medical Services" (p. 32-36) Section of the Work Plan.

(10) "That determinations of eligibility for services under each program will be made by the program director or a member of the program staff designated by him, and will be in accordance with the Act, these regulations and the policies and procedures promulgated thereunder, and in accordance with the approved state plan."

See discussion under 51a.125(b)(5).

(11) "That the program of projects will be in addition to the demonstration services referred to in 51a.117."

Our special demonstration project will be a program to provide family planning services to residents of Rosebud and Treasure Counties. These are two of the counties in Montana that have been most affected by the tremendous influx of young families who provide the labor force for the coal strip-mining operations. The counties' rapid development has been caused by the national emphasis on coal development. The program will demonstrate the method, need and feasibility of providing family planning services to a rapidly expanding, mobile population. Funds for the program have been applied for from the Old West Regional Commission.

(12) "That to the extent that funds are inadequate for the provision of necessary family planning services, the program of projects will be curtailed in terms of areas or population served, or similar factors, and not in terms of the care and services provided under the program."

The services and care outlined in the Work Plan (p. 16-40) of The State of Montana Family Planning Program will not be reduced in the case of inadequate funding. Instead, inadequate funding will result in a reduction in the number of programs in the state.

SECTION V. D. CHILDREN AND YOUTH PROJECT

Lewis & Clark Children & Youth Project

Report and Plan for F.Y. 1976

1. Evaluation of F.Y. 1975

This was the first year of working with the "Management by Objectives" concepts which, if directed toward the total Project activities, would have resulted in a concise evaluation of all measurable changes. The MBO statment as submitted with last years plan was later recognized as being too comprehensive and difficult for a first-time experience, so the objective statement was revised and narrowed down to a manageable size. In brief, we set as the goal a 10% reduction in the need for referral for care, in both medical and dental screenings. It was necessary to make some changes in statistical reporting from clinic, in order to compare initial assessments to recall assessments.

An evaluation has been done quarterly to determine if we were, in fact, meeting our goal of reducing referral needs, when a child was re-assessed. The first quarter evaluation, as well as subsequent evaluations, shows that we were too modest in estimating what was being accomplished. Need for dental referrals dropped from 76% at initial assessment to 48% at re-assessment. Severity of need (Class I) was reduced from 12% at initial assessment, to 0.7% at re-assessment. Reduction of referrals was a spectacular 35%. Medical assessments statistics show that the percent of referrals dropped comparably by about 33%.

Tabulation of 1975 MBO evaluation for 3 quarters as appears as Exhibit #6 in the appendix.

As the MBO objective measured only one part, but an important one, of total services, other indices are presented. Helena School District #1 has just surveyed its health records to determine the immunization level of students enrolled in Kindergarten, first grade, and seventh grades. Their immunization reports were sent to the health department to see if immune records on file here, from public and C & Y immunization efforts, had additional information that was not on school records. This gave us the opportunity to compare the status of C & Y-enrolled students, to that of non-C & Y-enrolled students. There is 100% up-to-date immunization of C & Y enrollees in Kindergarten, first and seventh grades, compared to 30% up-to-date immunization of those not enrolled, based on records available. This is an immune level of slightly under 50% for total students. The worst group is the seventh grade group, with lack of M-R, or "no records" being the factor that brings down the percentage. However, because of the age of this group, many of them have had measles and rubella disease before immune vaccines were developed, and would probably be considered adequately immunized if health information was complete on school records.

In F.Y. 1974, medical and dental assessments and re-assessments were being kept fairly close to recognized medical and dental standards. F.Y. 1975 is showing a time lag, not yet critical, but a lag, nonetheless. Factors that seem to contribute to this, even though total case load remains about the same, are the transience of newer enrollees; an increasing number of enrolled babies needing frequent medical assessments, and the loss by resignation of the pediatric nurse specialist who had been doing some of the re-assessments.

SECTION V. D. CHILDREN AND YOUTH PROJECT (continued)

The Project has been able financially to maintain its usual services and care for eligible children through age 12, which has been the upper age group for the past three years. This has been possible because there were enough carry-over federal funds to add to the $312,000.00 made available from state funds, to operate at a level which has previously been funded at $339,000.00 per year. State funds for F.Y. 1976 in the amount of $302,000.00 leaves us hard-pressed if we hope to maintain this Project at its current strength. Alternate plans of action are reported later in this narrative.

II. Changes in F.Y. 1975, and their impact

A. Resignation of Pediatric nurse specialist.

The need for a nurse trained to do well-child assessments was recognized by the Project at least 3 years ago. In 1972, an interested staff nurse was sent for 2 weeks of intensive assessment training, then worked closely with the Project pediatrician for 2 months before starting independent child assessments at a weekly clinic. Her yearly average of about 130 children seen made it possible to keep medical assessments up to date for all enrollees. This reduction in number of children assessed has contributed to the lag now occuring in assessment schedules. The project is anxious to re-establish this service, but a comparable course of training has not yet been found. An already-trained person, if available, could be employed to fill a staff vacancy, but not as an addition to the current nurse staff.

B. The position of Licensed Practical Nurse has been discontinued. Her main assignment had been to work in the clinic 4 mornings a week, and her afternoons had been used to help with home nursing care. As the Home Health Agency developed its program, there were fewer cases for this health agency. There were limited activities to which an LPN could be assigned. On the LPN's resignation, her job assigned was re-evaluated, and it was determined that the job she had been doing in clinic (specimens, weighing and measuring, vision testing, etc.) could be dependably accomplished by a clerk-aide. This clerk-aide has the remainder of her time assigned to clerical services for the nursing department, and to help on clinic statistics and records. This change was accomplished through re-assignments to the current clerical staff, and no replacement is contemplated.

C. Fee Schedule Changes.

Effective December 1, 1974, the medical fee schedule was increased, to maintain parity with the State Health Departments Crippled Childrens Services Conversion Value. This was approximately an over-all 5% change. At the same time, dental fees were increased by 10%, a value currently being paid by Medicaid. This latter decision was made after consultation with the Director of State Health Department Dental Bureau to determine what was a reasonable fee.

In spite of these increases, our allowable payments still are below most physicians charges, and a few dentist's charges.

D. Provider Status and Collections.

During F.Y. 1975, we have had a clerk being trained in collections for third party payments. The 12-month training period has been entirely subsidized thru the Work Incentive Program. Starting in September, with State and local Board of Health Approval, claims have been filed to health insurance companies for services provided in the clinic. This has not been especially remunerative, as many of our enrolled families do not have health insurance, and of those that do, benefits for office-type care are rather limited. The reaction of families to a request for their signature on an insurance claim has been mainly non-committal, but some have indicated that they think its a good idea. These enrolled families feel that since they are paying health insurance premiums, the services they receive from us should be billed to their insurance company, so that C & Y could have some partial re-payment. The patients can feel that they are therefore in less of a "charity" situation.

Effective January 1, 1975, a provider contract with Medicaid became effective, after a long period of planning, revisions, and final completion. The services for which we can receive payments are mainly for para-medical services and therapy, and dental preventive services. Our contract with SDHES to participate in Title XIX EPSDT covers medical and dental examinations, so no duplicate charges can be made for these services.

At this point in collections, the net return on this activity offers a few thousand dollars to augment patient care costs.

Copy of Agreement with SRS appears as Exhibit #7.

E. WIC Implementation.

On March 10, 1975, the WIC Program became operable. The plan had been to start operation with current C & Y Staff, so about half our clerical staff was involved in some informational and training sessions, both within and outside the agency. When start-up funds were made available from SDHES, a WIC aide was employed in mid-March. The initial response was great enough that there would have been difficulty in operating the plan without additional staff. A Health Educator Trainee, who had been assigned to the nutritionist for training, has been working with the WIC Program, along with the WIC aide. Participation statistics at this writing do not seem indicated.

Proposed F.Y. 1976, WIC budget appears as Exhibit #2.

F. Motor Pool Participation.

Starting late in October 1974, the agency has been participating in the State Motor Pool for the 2 outreach workers. These positions require a vehicle, but the pay is low, and it has been difficult financially for these 2 employees to maintain a well-operating car and carry business-use insurance,

on a reimbursement of 12¢ a mile. The agency had previously leased 1 car from a commercial source, and had tried to shift the longer driving to this car. It was an expensive service, but there had been no available cars in the Federal Motor Pool. With the change in the source of funding effective July 1, 1974, a request was directed to State of Montana Motor Pool to consider our qualifications for participation. The request was approved, after we had received our first funds from the Montana State Treasurer in September 1974.

After 6 months of Motor Pool participation, the average monthly cost of travel by 2 outreach workers is slightly below the cost of one commercially leased car. In addition to the reduced cost to the agency, we are no longer faced with the possibility of only one car available because of needed repairs, and the outreach workers do not have the pressures of keeping a car in tip-top shape, or insured for business use.

G. Head Start Re-Negotiation.

A new agreement was concluded with the Head Start Program in September of 1974. Through the course of the Head Start year, charges are made for medical and dental examinations of Head Start enrollees. Because some of the children have their examinations in the summer when Head Start is not in session, no charges can be made, but money is left in the childs account. In April, before the end of Head Start fiscal year, we may submit re-imbursement request for health care that C & Y has paid for during the year, and can recover some of the money from accounts that had not been used for examinations at C & Y Clinic. Under the previous agreement of asking only for re-imbursements of C & Y money spent on health

care, some of the medical and dental accounts of Head Start enrollees remained intact, even though they had received staff services from C & Y. Copy of this agreement is Exhibit #8.

H. New Working Arrangement with Maternal & Child Health Services, Montana State Department of Health.

Many referrals, particularly in orthopedics, that the Project has made to the Crippled Childrens Program of the State Department of Health have required no more than an evaluation of the child, with minimal or no recommendations for care. In order to eliminate unnecessary applications, and inactive patient records, State Department of Health has agreed to pay the cost of these simple evaluations without a formal application being filed.

A report of orthopedic evaluation, by child name, is submitted each quarter, along with a vendor request for re-imbursement of evaluation costs.

For those evaluations that produce recommendations for care that should be registered with State Health Department, the usual routine of a full application is accomplished. From our side, we find that it has reduced time and record making, without affecting our cooperation and coordination with the State Health Department.

A copy of this agreement appears as Exhibit #9.

I. Health Educator Trainee.

Through the Public Service Employment Program, the agency has had a Health Educator trainee since mid-December 1974. It will require 2 years of training in a health agency to become qualified as a Public Health Educator II. Our trainee has a B.S. in elementary education, with a major in Special

Education and handicapped children. As her assignments rotate through all the specialty areas, she is learning health, and is teaching some educational principles to the staff. She is helping in planning workshops, meetings, reports, etc.

J. Financial Participation by Enrollees.

A new schedule has been developed for financial participation by those families whose income is above our eligibility standards. The current schedule is now in line with that used by Child Health Services in determining how much a family should pay toward their health care.

Our schedule requires very little participation by those families who are only slightly above our allowable income level, but requires increasing percentages as the income becomes higher above our allowable level. There is no intent to withdraw services where there is a need for our financial help, but neither should we spend our money injustifiably.

A copy of financial participation requirements appears as Exhibit #5.

K. Final Severance of Direct Association with Region VIII Department of HEW.

March 31, 1975 was the last date of the Project having any direct responsibility to, and working relationship with Region VIII. As of that date, all financial transaction had to be completed, and all federal money spent. Those requirements were met. Instruction have been received detailing reports that must be submitted no later than June 30, 1975. This requirement will be met.

III. Plans for F.Y. 1976

A. Objectives

1. General

The project will continue its activities of furnishing comprehensive health services to children of low income families, in its eligible age group. The emphasis will remain on prevention, with early detection and treatment.

2. MBO

As our contribution to the needs of the Maternal and Child Health Bureau, we will implement a Quality of Care Evaluation. Their goal statement has been received, and we hope for an early conference on implementation, as it may mean some change in encounter statistics collecting. Also, a "severity range" scale will need to be determined, so that all MCH statistics will be comparable.

B. Meeting Increased Salary Schedule

The nursing staff's negotiation unit, The Association, has presented to the agencies their contract requests for the fiscal year 1976. The previous contract for F.Y. 1975 had brought a 2-step advancement of the salary schedule, which had been anticipated in the budget for F.Y. 1975. In addition to salary increases, a payment of $30.00 per year toward the cost of car insurance for the nurses who used their car on the job, was also part of last years contract.

F.Y. 1976 request is for a straight 15% salary increase which is slightly more than a 3-step advancement on the merit system pay scale. Also, salary increases are requested at 6-month intervals, which would mean, in effect, a 20% increase the first year. Other requests that will

increase costs are: The agencies to furnish 3 cars; educational assistance of 100% of tuition expense for up to 6 credit hours; compensatory time to be at the rate of 1½ hours for each hour worked outside regular working hours; and 12 days of educational leave per year, as compared to the current 5-day per year minimum.

Last year there was a reduction in the clerical staff and outreach staff, but the nursing staff remained intact.

If the current contract is signed as presented, there may have to be considerable reductions in staff, services, and enrolled children. The submitted budget is based on the distinct possibility that there will be at least a 1-step salary scale adjustment granted, which, under Merit System rules, cannot be selective but must be adjusted for all. Requested and proposed pay scale appears as Exhibit #4.

C. Dental Health Program

The Dental Hygiene Training Program at Carroll College will have students needing field training beginning in September 1975. The students will be under the direct close supervision of a teaching Dental Hygienist. A local dentist has a chair and power unit that he is contributing to this training program. When the Administration of Shodair Hospital designates a location for this equipment to be installed in the hospital, hopefully near the C & Y dental clinic, our dental patients will be available for student field experience. This will increase the Projects capabilities of maintaining dental re-assessments on schedule. Final arrangements have not yet been worked out, so the financial value of this service to the Project has not been determined.

D. Operating within Financial limits

Obviously, with increases in the Salary Scale, increased costs of health care and of operating supplies and service, coupled with a reduction in grant funds, maintaining the status quo is not possible. Some alternative plans have been considered, and may or will be operative as the need arises.

1. Re-assess obligations to those families who do not qualify for health care at project expense. Any family who applied would be furnished the full screening and diagnostic service. If no health problem existed, enrollment would be closed. If a health problem was found, referrals for care would be made, and the case followed until such time as miximum benefits had been received. Perhaps a re-assessment at that point to validate the child's health status, then closure could be accomplished. The parent, of course, would be informed that they would have free access to the Health Department's preventive programs, and a public health nurse could be contacted if the parent felt the need for such a consultation. This alternative would reduce the on-going work load of all the staff, which would be of particular value if a staff reduction becomes necessary. This alternative would be easier to apply to the new enrollee than it would be to those of longer enrollment, since the latter group does like the health supervision their children have been receiving from staff personnel.

2. Charges for services, for those not from low-income families. (This possibility is part of Proposed Regulations in Federal Register Volune 40, Number 58, Part III dated March 25, 1975). These direct

charges would be only for those staff services that do not fall within the definition of diagnostic, screening, and preventive services which will continue to be available without charge to all children. Some parents come to enroll, and state they are interested only in certain staff services, such as, speech therapy, psychological testing, help with child behavior problems, etc. These sometimes are parents who have considerable income, and could pay if there was such a private resource available. We could offer them the alternative of paying the project for service, or informing them of a private source of therapy. This alternative, if operative, would either reduce enrollment, or offer a small amount of income to the project.

3. Reduction of enrollment, by lowering the upper age limit of eligibility. This would be accompanied by a decrease in staff. This is an alternative that is least acceptable, because it has no relationship to health needs.

Alernatives #1 and #2 would be chosen before alternative #3, as they allow for consideration of those children who have the greatest need for our help.

SECTION V. E. DENTAL HEALTH

Flathead County Children's Dental Health Project

A. GOAL

Other areas in the United States could well take a long, hard look at the Flathead County Children's Dental Health Project as a meaningful demonstration of a method to improve the dental health of children when consideration is given to developing a dental health program. During the four years of its existence, the goal of improving the dental health of all first grade children in Flathead County has been expanded to include all elementary school children grades one through six.

B. OBJECTIVE

The objectives of the Project are (a) to provide a comprehensive dental care program to children from medically indigent families at an early age to minimize their need for dental care as they grow older; (b) to provide a program of preventive dentistry to all elementary school children in the county; (c) to make a dental health education program available to all elementary school children and their parents; and (d) to demonstrate methods of providing these services in an area where no public health dental facilities are available, using effectively a dental hygienist in the school systems to provide screening, prevention, and dental health education, and providing comprehensive dental care through the private sector of dentistry.

During the planning stage of the Project, the Project Director and the Project Staff (six dentists and two dental hygienists) designed methods of meeting these objectives. All of them have been and are being accomplished.

The Project is essentially separated into two portions -- the dental care portion and the screening, preventive, and dental health programs provided by the project dental hygienist in the Flathead County schools. Both portions run efficiently and well.

From the time the children are referred to the Project Secretary for eligibility determination and referral to the dentist of their choice for treatment, both the consumer and the provider dentist have been happy with the Project's functions. The use of the services of Delta Dental Plan, a dental service organization, has been an especial asset to the program. Preauthorization and periodic peer review by Delta has kept the Project clean regarding overutilization or excessive fees being charged. Delta has also been a satisfactory fiscal agent for payment of dental fees and reporting services to the Project.

For the first time, this year a full-time dental hygienist was employed to supervise the school portion of the Project and for the first time, most of the plans for the Project are rounding into shape. All of the elementary school children grades one through six were offered the screening, preventive, and dental health education programs. 4,607 children participated.

SECTION V. E. DENTAL HEALTH
(Continued)

As reported in earlier reports, the evaluation or measure of the impact on dental health of the Project, is built in to the screening program by classifying the children as to emergent need of dental care -- Class I, meaning the child needs emergent dental care; Class II, meaning the child needs some dental care; and Class III, indicating no dental care is needed by visual examination.

The results of the screening this year continue to indicate a tremendous impact on the dental health of children in Flathead County. Although almost double the number of children were screened this year, the percent of Class I's remains about the same percentage this year -- 6% last year, 7% this year; Class II's have been reduced from 33% last year to 29% this year; and the Class III's increased from 61% last year to 64% this year. It is gratifying to the Project Director and Staff to know that almost two-thirds of the children in the County have no need for dental care and that the number needing emergent care has been cut by approximately one-half.

Of special interest in the screening results is the group of children screened in the first year of the Project who, at that time, were first and second graders and showed 12% Class I; 44% Class II; and 44% Class III. Four years later, as fourth and fifth graders, they show as 6% Class I; 30% Class II; and 64% Class III -- again very gratifying.

Last year's progress report predicted that the screening results would not improve unless some additional preventive measures could be added to the Project. Three such measures have been made possible with the dental hygienist in full-time employment.

1. Nutritional consultation has been initiated by the hygienist for parents of children in the Project who return for recall appointments and incur excessive treatment charges.

2. Class I children are being individually contacted by the hygienist and referred to their dentist or to the Project for treatment.

3. The Project and the PTA Councils have cooperated in initiating a Fluoride Mouth Rinse Program in all of the Kalispell and Columbia Falls schools. 2,221 children -- 85% of the toal enrolled -- are participating in the fluoride rinse.

Everyone connected with the Project is enthusiastic in supporting it. The Flathead County Commissioners are considering almost doubling the hard money match next year to increase the benefits of the Project. School administration and members of the PTA Councils insisted on expansion of the Fluoride Mouth Rinse Program instead of starting it out on a small scale in two schools. The dentists are happy that they can provide care at their usual and customary fee for a group of children who otherwise would just not receive care and end up dental cripples. Most important, the parents of the children involved in any aspect of the Project realize that dental care, prevention, and education combine to reduce their bill for dental care and improve the health of their children.

The Project Director and Staff consider the Project to be a model for public dental health programs. Project hygienists have presented this philosophy through the media of table clinics to an international meeting in Mexico City, an annual meeting of the American Dental Association in San Francisco, and an Idaho-Montana Dental Association Bi-State meeting in Sun Valley. The Project Director has sung the Project's praises before a Regional Maternal and Child Health meeting in Denver and at several meetings of the Council on Dental Health of the Montana Dental Association.

The Flathead County Children's Dental Health Project is a model for other communities and/or counties in Montana. With the financial support of Flathead County and the block grant from Maternal and Child Health Services, it will be continued under the state program of projects. Perhaps at some point in the future, similar programs can be funded statewide.

STATEWIDE NEED

Children from medically indigent families in Montana have no access to dental care except through the Flathead County Children's Dental Health Project, the Lewis and Clark County Child and Youth Project, and Title XIX Medicaid benefits. On July 1, 1975, all benefits for the medically indigent will be dropped from Title XIX Medicaid Program. This leaves just the two county programs available to provide dental care benefits.

The need for dental care benefits, preventive services, and dental health education provided by the Flathead County Children's Dental Health Project is universal in Montana for children of medically indigent families. As funds become available, planning must be accomplished to provide these services statewide.

ASSURANCES

1. The program of projects will provide services particularly in areas with concentrations of low-income families, with priority given to the areas having the greatest need for such services, whether urban or rural.

2. Diagnostic, screening, and preventive services will be available without charge to all children within the area served by the program of projects.

3. Treatment, correction of defects, or aftercare will be available only to children who otherwise would not receive such services because they are from low-income families or for other reasons beyond their control.

SECTION V. E. DENTAL HEALTH
(Continued)

ASSURANCES (continued)

4. Services will be available to children from outside the area served by the project only if it is determined by the project director that provision of such services will best promote the purposes of the program of projects under this section.

5. Treatment, correction of defects, and aftercare will be provided to children and youth who are not from low-income families but who would not otherwise receive such services for reasons beyond their control only if such treatment does not reduce the delivery of necessary services to children from low-income families. In those instances where charges are made for treatment services provided to children who are not from low-income families, such charges shall be applied flexibly with due regard to family size and income and the family's other financial responsibilities in relation to the cost of required care. Full disclosure of such payment scales and the factors by which they are applied shall be made available to the providers as well as to the patients and their families. The established basic payment schedule shall not exceed actual costs. Every reasonable effort will be made to collect from third-party payment sources (including Government agencies) which are authorized or under legal obligations to make such payments. Where the cost of care and services furnished by or through the program of projects is to be reimbursed by a Government agency, a written agreemnt with that agency is required. Reimbursement may be made either to the project or directly to the provider, in accordance with such agreement.

6. The program of projects will be administered by the State Maternal and Child Health Program unit, either directly or through grants or contracts. The Dental Bureau of the State Department of Health and Environmental Sciences will have direct responsibility for the Flathead County Children's Dental Health Project. The Chief of the Dental Bureau will act as project director.

7. Dental care and services provided by the project will be under the direction and responsibility of dentists with appropriate training and experience.

8. Determinations of eligibility for services under the project will be made by the project director or a member of the project staff designated by him and will be in accordance with the Act, these regulations and the policies and procedures promulgated thereunder, and in accordance with the approved State plan.

9. To the extent that funds are inadequate for the provision of comprehensive dental care and services, the program of projects will be curtailed in terms of areas served or age levels of children served, or similar factors, and not in terms of the care and services provided under the program.

SCHOOL PREVENTIVE DENTISTRY PROGRAM
DENTAL DEMONSTRATION PROJECT

I. NEED

The two most prevalent dental diseases, dental caries and periodontia (gum diseases), afflict almost 100% of the population in Montana as well as the rest of the United States. A large part of these diseases can be prevented by application of good preventive procedures that improve oral hygiene. Establishing a habit of proper oral hygiene early in life will serve to protect Montana school children against dental disease throughout their lifetime.

II. GOAL

To improve the oral hygiene and thus, the dental health of Montana school children.

III. OBJECTIVE

A. To provide Montana elementary school children with a dental health education program that will include a lecture on cause and effect of dental disease, nutritional advice, and a method of controlling their own dental disease through plaque removal.

B. To provide each elementary school child with a toothbrush annually and demonstrate an accepted, effective way of using it for removal of dental plaque.

IV. ACTIVITIES

1. Submit an appropriation bill to the Montana Legislature to fund employment of two dental hygienists, purchase of all supplies necessary to program and travel expenses for hygienists.

2. Train dental health educator in dental health education lectures and demonstration of plaque removal techniques.

3. Make the dental health educator responsible for implementation of the program for approximately more than 55,000 school children throughout the state. Elementary school population is about 110,000.

V. EVALUATION

A before and after Personal Hygiene Performance Index will be accomplished on a study group of children to determine effectiveness of program.

VI. STATEWIDE COVERAGE OF PROGRAM

The plan for this program was to carry it statewide by July 1, 1975. The Montana Legislature turned down the appropriation bill submitted to cover adequate funding for the program. Available funds permitted the use of the alternate plan of a dental health educator and using volunteers to provide program services to in excess of 50,000 Montana school children.